(1)

91-782

NO.

IN THE SUPREME COURT OF THE
UNITED STATES

OCTOBER TERM, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,
Petitioners

v.

TEMPLE UNIVERSITY--OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,
Respondents

On Petition for Certiorari To The
United States Court of Appeals
for the Third Circuit

PETITION FOR CERTIORARI

ERNEST D. PREATE, JR.
Attorney General

By: JOHN G. KNORR, III
Chief Deputy Attorney General
Counsel of Record

KATE L. MERSHIMER
Senior Deputy Attorney General
(Counsel continued on inside
cover)

Office of Attorney General
15th Floor, Strawberry Square
Harrisburg, PA 17120
(717) 783-1471

JOHN A. KANE
Chief Counsel

THOMAS B. YORK
Chief of Litigation
Pa. Department of Public
Welfare

Department of Public Welfare
Office of Legal Counsel
309 Health & Welfare Building
Harrisburg, PA 17120
(717) 787-4063

CARL H. SHUMAN
Deputy General Counsel

Office of General Counsel
333 Market Street
Harristown II
17th Floor
Harrisburg, PA 17101
(717) 783-6563

QUESTIONS PRESENTED

I. Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. §1983 to enforce the Medicaid Act against a State?

II. Whether a federal court can attribute to Congress an unstated intent to impose on a state increased funding obligations under the Medicaid Act?

LIST OF PARTIES

The petitioners are Karen Snider, the Acting Secretary for the Pennsylvania Department of Public Welfare (DPW); David S. Feinberg, the Acting Deputy Secretary for the Office of Medical Assistance Programs, DPW; David D. Ulsh, the Director of the Division of Inpatient Programs, Bureau of Hospital and Outpatient Programs, Office of Medical Assistance Programs, DPW; G. June Hoch, Chief of Specialty Hospital Programs, Division of Inpatient Programs, Bureau of Hospital and Outpatient Programs, Office of Medical Assistance Programs, DPW; Michael H. Hershock, the Secretary for Budget, Office of the Budget, Governor's Office, Commonwealth of Pennsylvania; Carolyn Franklin, Western Regional Representative of Public Welfare, DPW; and Patricia Hughes, Southeastern

Regional Representative of Public Welfare, DPW.

The respondents are Temple University, Albert Einstein Medical Center, Allegheny General Hospital, Children's Hospital of Pittsburgh, Episcopal Hospital, Giuffre Medical Center, Magee-Women's Hospital, Mercy Catholic Medical Center- Misericordia Division, Mercy Hospital of Pittsburgh, Montefiore Hospital Association of Western Pennsylvania, Inc., Presbyterian University Hospital of Pittsburgh, St. Christopher's Hospital for Children, St. Joseph's Hospital, St. Mary Hospital, Western Pennsylvania Hospital, Germantown Hospital and Medical Center, Hahnemann University Hospital, Presbyterian Medical Center of Philadelphia, the Trustees of the University of Pennsylvania, Allegheny Valley Hospital, The Allentown Hospital,

Allentown Osteopathic Medical Center, J.C. Blair Memorial Hospital, Braddock General Hospital, Bradford Hospital, Brandywine Hospital, Butler Memorial Hospital, Carbondale General Hospital, Central Medical Center and Hospital, Chambersburg Hospital, Chester County Hospital, Chestnut Hill Hospital, The Children's Hospital of Philadelphia, Charles Cole Memorial Hospital, Clarion Osteopathic Community Hospital, Clearfield Hospital, Community General Osteopathic Hospital, Community Medical Center, Conemaugh Valley Memorial Hospital, Divine Providence Hospital, Divine Providence Hospital of Pittsburgh, Doylestown Hospital, Dubois Regional Medical Center, Ephrata Community Hospital, Eye & Ear Hospital of Pittsburgh, Forbes Metropolitan Health Center, Forbes Regional Health Center,

Franklin Regional Medical Center, Frick Community Health Center, Geisinger Medical Center, Geisinger Wyoming Valley Medical, The Germantown Hospital and Medical Center, Gettysburg Hospital, Gnaden Huetten Memorial Hospital, Good Samaritan Hospital, Greene County Memorial Hospital, Hamot Medical Center, Hanover General Hospital, Harrisburg Hospital, Highlands Hospital and Health Center, Indiana Hospital, Jameson Memorial Hospital, Jeannette District Memorial Hospital, Jefferson Hospital, Andrew Kaul Memorial Hospital, Kensington Hospital, Lancaster General Hospital, Lankenau Hospital, Lee Hospital, Lehigh Valley Hospital Center, McKeesport Hospital, Meadville Medical Center, The Meadville Medical Center, Beaver, Pa., Inc., Medical College of Pennsylvania, Memorial Hospital, Memorial Hospital of

Bedford, Mercy Catholic Medical Center, Fitzgerald Mercy Division, Mercy Hospital, Altoona, Methodist Hospital, Millcreek Community Hospital, Monongahela Valley Hospital, Muhlenburg Hospital Center, Northeastern Hospital of Philadelphia, North Penn Hospital, Osteopathic Medical Center of Philadelphia, Pennsylvania Hospital, Phoenixville Hospital, Pottstown Memorial Medical Center, Pottsville Hospital and Warne Clinic, Punxsutawney Area Hospital, The Penn State Hospital/Milton S. Hershey Medical Center, Quakertown Community Hospital, Reading Hospital and Medical Center, Roxborough Memorial Hospital, St. Agnes Medical Center, St. Francis Medical Center, St. Joseph's Hospital, Carbondale, St. Joseph Hospital, Lancaster, Sacred Heart Hospital, Sewickley Valley Hospital,

Shadyside Hospital, Sharon General Hospital, Southern Chester County Medical Center, Suburban General Hospital, Sunbury Community Hospital, Taylor Hospital, Tyler Memorial Hospital, Tyrone Hospital, Westmoreland Hospital Association, Wilkes-Barre General Hospital, The Williamsport Hospital & Medical Center, York Hospital and Greenville Regional Hospital, Altoona Hospital, Bloomsburg Hospital, Brownsville Hospital, Bryn Mawr Hospital, Canonsburg Hospital, Carlisle Hospital, Citizens General, Community General Hospital, Reading, Community Hospital of Lancaster, Crozer-Chester Hospital, Delaware County Memorial Hospital, Easton Hospital, Ellwood Hospital, Grand View Hospital, Jeanes Hospital, Jersey Shore Hospital, J.F. Kennedy Hospital, Lower Bucks Hospital, Metro Health Hospital,

Metropolitan Hospital, Central, Metropolitan Hospital, Parkview, Metropolitan Hospital, Springfield, Montgomery Hospital, Paoli Hospital, Pocono Hospital, Sacred Heart Hospital-Chester, Saint John's Hospital, Hazelton-Saint Joseph's Medical Center, Saint Joseph Hospital, Reading, Saint Luke's Hospital, Saint Margaret Memorial Hospital, Saint Vincent's Hospital, Suburban Hospital, Titusville Hospital, Uniontown Hospital, Washington Hospital, and The Wayne County Memorial Hospital.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

STATUTES

REGULATIONS

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Third Circuit is reported at 941 F.2d 201 and is reprinted in the appendix at 1a. The opinions of the United States District Court for the Eastern District of Pennsylvania are reported at 729 F.Supp. 1093 and 732 F.Supp. 1327, and are reprinted in the appendix at 53a and 93a, respectively.

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was filed on July 30, 1991, App. 1a, and this petition is being filed within 90 days thereafter. The Court has jurisdiction to review this judgment pursuant to 28 U.S.C. §1254(i).

STATUTORY PROVISIONS INVOLVED

1. 42 U.S.C. § 1983 provides in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State ... subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress.

2. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-19396u, known as the Medicaid Act, provides in relevant part, at 42 U.S.C. § 1396, as follows:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children whose income and resources are insufficient to meet the costs of necessary medical

> services...there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

3. 42 U.S.C. § 1396a(a) of the Medicaid Act also provides in relevant part:

> A State plan for medical assistance must--...
>
> (13) provide--
>
> (A) for payment ... of the hospital services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and

> economically operated facilities ... and to assure that individuals eligible for medical assistance have reasonable access ... to inpatient hospital services. ...

4. 42 U.S.C. § 1396r-4 of the Medicaid Act further provides in relevant part:

> [A] payment for a disproportionate share hospital must either --
> (1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);
> (2) provide for a minimum specified additional payment amount (or increased percentage payment) and ... for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate ... exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in

the State or the hospital's low income utilization rate ...; or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that --

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients.

STATEMENT OF THE CASE

1. This action challenges Pennsylvania's administration of the Medical Assistance or "Medicaid" program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-1396u. The respondents, Medicaid providers and a representative organization, attack the adequacy of the payment rates Pennsylvania has established for their services. In particular, they claim that the disproportionate share payment made by the Pennsylvania Department of Public Welfare (DPW) is lower than the level of payment mandated by 42 U.S.C. § 1396r-4.

a. Medicaid is an exercise in "cooperative federalism," Harris v. McRae, 448 U.S. 297, 308 (1980), in which the state and federal governments work together to provide, "as far as

practicable under the conditions in each state," medical assistance to poor people. 42 U.S.C. § 1396. To receive the federal financial assistance made available by the act, a state must submit to the Secretary of Health and Human Services, and have approved by him, a "state plan," ibid, the contents of which are prescribed by 42 U.S.C. § 1396a(a).

Regarding hospital services, the act requires that the state plan "must ... provide ... for payment ... through the use of rates ... which the state finds, and makes assurance satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a) (13)(A). These payments must also take into account the situation of hospitals serving disproportionate numbers of poor patients. Ibid.

The act specifically defines these "disproportionate share" hospitals, 42 U.S.C. § 1396r-4(b), and requires the state plan to provide for an "appropriate increase," 42 U.S.C. § 1396r-4(a)(1)(B), in their payment rates. In setting this "appropriate increase," a state plan may adopt the figure used in the federal Medicare program, 42 U.S.C. § 1396r-4(c)(1), or may adopt its own methodology, 42 U.S.C. §§ 1396r-4(c)(2), 1396r-4(c)(3). If the state chooses to use its own methodology, the "appropriate increase" must be proportionate to the percentage by which a hospital's share of medicaid- eligible patients exceeds the norm, 42 U.S.C. § 1396r-4(c)(2), or must be "reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance," 42 U.S.C. § 1396r-4(c)(3)(B).

b. When it submitted State Plan Amendment 88-12 to the Health Care Financing Administration (HCFA), DPW chose not to use the Medicare formula for determining disproportionate share payments. Instead, as authorized by statute, DPW determined the disproportionate share payment as follows:

(1) The hospitals were ranked, from high to low, by the hospital's ratio of federally funded medical assistance days (Title XIX days) to total days;

(2) The rankings were divided into five payment brackets with ties resolved by moving a hospital into the next higher bracket; and

(3) For fiscal year (FY) 1988-89, qualifying hospitals, of which there were 48, received

the following add-ons to their group rate:

Payment Bracket	Percentage Add-On	No. of Hospitals
1	2.5%	11
2	2.0%	10
3	1.5%	11
4	1.0%	12
5	0.5%	4

HCFA, consistent with its statutory authority, approved DPW's disproportionate share payments, as prescribed in State Plan Amendment 88-12, on August 28, 1989.

2. This action was brought originally as several separate but related actions before the United States District Court for the Eastern District of Pennsylvania. The District Court had jurisdiction of these related actions pursuant to 28 U.S.C. §§ 1331, 1343.

Although recognizing that the "statute does not mandate any particular level of payments for disproportionate-share hospitals," App. 81a, the District Court initially held that DPW's rates failed "to adequately take into account the circumstances of hospitals which serve a disproportionate number of low-income patients with special needs." App. 88a. The District Court stated:

> By specifying either the Medicare system or an alternative system devised by the States, Congress seems to have contemplated that the State's plan would produce comparable results. The 2.5% override provided by the Pennsylvania Plan is only about 1/10 of the amount which would be payable [to Temple University] under the Medicare analysis (2.5% versus 20.93%).

> Recognizing that States are given a considerable amount of flexibility in this area, and that reimbursement rates are to be fixed by the State, not by this court, I am nevertheless constrained to hold that Pennsylvania's adjustment for plaintiff's disproportionate-share status misses the mark by so wide a margin as to be inconsistent with the intent of Congress.

App. 82a-83a. In later granting interim relief, the District Court stated that "Congress intended disproportionate share institutions to receive an adjustment in the same ball park as the Medicare calculation would produce." App. 99a. Based upon a comparison with the Medicare rate, the Court found "on an interim basis, the disproportionate share add-on [for Temple University] should not be less than 10%." App. 100a-101a.

The District Court also found that DPW's basic Medicaid payment rates, were "arbitrary, and inadequate to meet the costs which must be incurred by efficiently and economically operated hospitals." App. 91a. In switching to a prospective payment plan, DPW applied an adjustment factor to limit the payments to an estimated amount that would have been paid under the old system. Consequently, DPW, after regrouping the hospitals, reduced the group average rates by a "budget neutrality factor" of approximately 14%. The District Court held that DPW failed to make the requisite findings that the rates were "reasonable and adequate" and thereby violated federal law. 42 U.S.C. § 1396a(a)(13)(A). App. 83a-87a. In the form of interim relief, the Court ordered that DPW apply to Temple University a budget neutrality reduction of no greater

than 2.4%. App. 98a-99a, 103a. In subsequent orders, the District Court applied identical interim relief to all the other respondents. App. 105a-112a.

3. The Court of Appeals for the Third Circuit had jurisdiction to review the orders of the District Court pursuant to 28 U.S.C. § 1292(a).

The Court of Appeals, after consolidating the appeals, affirmed the orders of the District Court.[1] The

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1 Before the Third Circuit rendered its decision, the petitioners and respondents entered into a Stipulation of Settlement. Under that Stipulation, the parties agreed to place the litigation in civil suspense for three years and to engage in a series of pooling transactions designed to draw down additional federal matching funds for the payment of enhanced rates. The Court of Appeals acknowledged the "highly conditional nature of the settlement" and found that the appeals had not been mooted. App. 17a-18a.

The pooling transactions have now been imperiled by interim federal regulations promulgated by the Health Care Financing Administration at 56 Fed. Reg. 46,380 (September 12, 1991). As a result, the issues raised by this petition are even more clearly not moot.

Court of Appeals did not specifically address the issue of whether disproportionate share payments under Medicaid must be comparable to the disporportionate share payments under the Medicare Program. It merely stated that the District Court found the 2.5 % add-on for Temple to be inadequate and then, after discussing the other issues, affirmed the orders "in all respects." App. 14a-15a, 51a.

This appeal followed.

REASONS FOR GRANTING THE WRIT

I. THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE REEXAMINED BY THIS COURT AS TO WHETHER A MEDICAID PROVIDER HAS A PRIVATE FEDERAL CAUSE OF ACTION UNDER 42 U.S.C. § 1983 TO ENFORCE THE MEDICAID ACT AGAINST A STATE.

In Wilder v. Virginia Hospital Association, ___ U.S. ___ 110 S.Ct. 2510 (1990), the Court held, in a 5-4 decision, that the Medicaid Act is enforceable in federal court pursuant to 42 U.S.C. § 1983. For the reasons explained in the dissent in that case per Chief Justice Rehnquist, and for the reasons set forth below, Wilder should be overruled.

As this Court recently held, precedent which is determined to be wrong ought not be followed slavishly, particularly when, as here, the holding in question was endorsed by the narrowest possible majority. Payne v. Tennessee, ___ U.S. ___, 111 S. Ct. 2597

(1991). Although constitutional precedents are generally more susceptible to being overruled than statutory ones, id. at 2610, section 1983 litigation raises quasi-constitutional issues. As Justice Powell once explained:

> The issued raised under § 1983 concerns a 'basic problem of American federalism' that 'has significance approximating constitutional dimension.' Monroe v. Pape, 365 U.S. at 22, 81 S.Ct. at 503 ([Frankfurter, J.] dissenting opinion). Although Mr. Justice Frankfurter's view did not prevail in Monroe, we have heeded consistently his admonition that the ordinary concerns of stare decisis apply less forcefully in this than in other areas of law.

Maine v. Thiboutot, 448 U.S. 1, 33 (1980) (Powell, J. dissenting). Principles of federalism, overlooked by the majority in Wilder and confirmed by events since that decision, counsel in favor of reconsideration of the Wilder majority's conclusion that the Medicaid Act confers rights on health care providers that are

privately enforceable against the states in federal court.

As this Court recently emphasized, the text of a statute must be the focal point of any interpretive enterprise, West Virginia University Hospitals, Inc. v. Casey, ____ U.S.____, 111 S. Ct. 1138, 1148 (1991), including an analysis of whether a plaintiff has a right to sue under section 1983 when the underlying federal statute on which the claim is based does not expressly create a private cause of action. See Wright v. Roanoke Development & Housing Authority, 479 U.S. 418 (1987). Yet, as Chief Justice Rehnquist observed in dissent, in holding that providers have an enforceable substantive judicial right under the Medicaid Program, the Wilder majority "virtually ignore[d] the relevant text of the Medicaid statute in this case."

Wilder, 110 S. Ct. 2525, 2526 (Rehnquist, C.J., dissenting). Specifically, Chief Justice Rehnquist explained that:

> [t]he Medicaid statute provides for appropriations of federal funds to States that submit, and have approved by the Secretary of Health and Human Services, 'State plans for medical assistance.'. . . The next provision in the statute specifies requirements for the contents of State medical assistance plans. § 1396(a). The provision in issue here, § 1396a(a)(13)(A), is simply a part of the thirteenth listed requirement for such plans. In light of the placement of § 1396a(a)(13)(A) within the structure of the statute, . . . one most reasonably would conclude that § 1396a(a)(13)(A) is addressed to the States and merely establishes one of many conditions for receiving Federal Medicaid funds; the test does not clearly confer any substantive rights on Medicaid services providers. This structural evidence is buttressed by the absence in the statute of any express 'focus' on providers as a beneficiary class of the provision.

110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting) (emphasis added) (citations omitted).

Simply stated, the language of the statute does not support a conclusion that Congress intended to create a substantive right enforceable by providers. Moreover, a careful review of the statute and the implementing regulations confirms that the only obligations imposed on the states concerning hospital reimbursment are to make findings and assurances to the Secretary and to obtain approval of the Secretary as a preconditon of federal funding. See 42 U.S.C. §1396a(a)(13)(A); 42 C.F.R. §§ 447.250-447.280. See also Wilder, 110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting). Ignoring the statutory language, the Wilder majority effectively converted the Medicaid Program into an entitlement program, not for poor people but for hospitals and other health care providers.

Even if the Wilder majority correctly concluded that providers have a right to "reasonable and adequate" reimbursement, the statute simultaneously prescribes the manner in which that right may be enforced, through congressionally mandated state administrative appeals and remedies. Notwithstanding the extensive state administrative payment rate review process that is currently in place pursuant to federal statute and regulation (including plan review and approval, public comment on changes to a state's payment system, and administrative challenge to individual payment rates), the Wilder majority created yet another avenue of redress that dissatisfied providers may pursue. In doing so, the Wilder majority has made it possible for hospitals, or their associations, to launch multiple attacks

in multiple fora on state reimbursement policies. Such a result not only flies in the face of congressional intent, but undermines the ability of states to administer their medicaid programs in any type of coherent manner. Indeed, as Chief Justice Rehnquist noted, Wilder enables providers to bring section 1983 actions to avoid the statutorily mandated process rather than to implement it, with the result that rates created in accordance with the statutory process are displaced by rates established by court order. See Wilder, 110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting).[2]

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[2] This affront to federalism and to the plain language of the act, discussed infra, is particularly evident and egregious in this case, where the respondents presented no evidence and where the district court made no findings or conclusions that Pennsylvania's payments under its federally approved state plan impede access of poor patients to inpatient hospital services. See 42 U.S.C. § 1396a(a)(13).

Although Congress intended to reduce federal oversight of state reimbursement schemes when it enacted the Boren Amendment,[3] the effect of Wilder was simply to shift this oversight from the federal bureaucracy to the federal courts. As predicted by Chief Justice Rehnquist in dissent, that effect is already being felt with alarming frequency and inevitably will have dramatic and potentially devastating repercussions upon the fiscal integrity of states which participate in the Medicaid Program. At least six states are currently facing Boren Amendment challenges from private providers who are seeking enhanced rates of reimbursement

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[3] The "Boren Amendment" was section 2173(a) of the Omnibus Budget Reconciliation Act of 1981, 95 Stat. 808, now codified at 42 U.S.C. § 1396a(a)(13)(A) and reproduced in relevant part at pp. 4-5, supra.

through the federal courts. See, e.g., Connecticut Hospital v. O'Neill, No. N-90-714 (D. Conn.); Abbeville General Hospital v. Ramsey, No. 91-356 (M.D. La.); Missouri Health Care Assoc. v. Stengler, 90-4307-CV-C-5 (W.D. Mo.); Nebraska Hospital Association v. Dept. of Social Services, 4-CV-91-3005 (D. Neb.); New Jersey Association of Health Care Facilities v. Gibbs, No. 90-1908 (D.N.J.); Illinois Hospital Association v. Edgar, No. 90 C 6394 (N.D. Ill.). At least two other states in addition to Pennsylvania, Washington and New York, already have had portions of their federally approved state plans invalidated at the behest of providers suing under section 1983. See Multicare Medical Center v. Washington, 768 F. Supp. 1349 (W.D. Wash. 1991); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991). There is every reason to

believe that this Court's decision in Wilder will only embolden other providers to challenge other federally approved state plans under section 1983 and thereby increasingly shift federal oversight of state Medicaid compliance from the executive branch to the federal judiciary.

The torrent of private provider challenges which Wilder has begun to unleash can only exacerbate the present and foreseeable inability of states to meet their Medicaid funding obligations and further distort Congress' original intent to create a cooperative federal-state program in which each state was to share in the cost of paying for services to the poor "as far as practicable under the conditions" in that state. 42 U.S.C. § 1396. As the Government Accounting Office recently

reported to the Senate Committee on Finance, Medicaid outlays between 1984 and 1989 generally represented the most rapidly growing segment of state budgets. See GAO Report No. HRD-91-78, reprinted in Medicare & Medicaid Guide (CCH) ¶ 39,495 at p. 27,362 (June 25, 1991). For fiscal year 1990, Medicaid constituted 12 percent of total state expenditures, second only to 23 percent for elementary and secondary education. Id. at p. 27,369. Moreover, total Medicaid spending is growing faster than spending for education and, from 1984 to 1989, increased at a faster rate than general revenues in all state spending categories. Id. In short, the Medicaid Program is eating the states alive and may well cause them to finance future program expansions "at least in part by cutbacks in Medicaid eligibility and/or

health services for low-income people not protected by mandates." Id. In other words, access of the poor to medical care may well be jeopardized -- not enhanced -- by additional congressional eligibility and services mandates.

Viewed in this light, it is highly doubtful and indeed unimaginable that Congress intended to give private providers a power of redress under section 1983 which can only destabilize state economies further by giving federal courts ultimate authority to invalidate HCFA-approved state plans and to pass upon the adequacy of HCFA-approved rates. The likelihood of harm to states and to the integrity of federalism makes reconsideration of this Court's decision in Wilder ever more compelling.

II. THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW AS TO WHETHER A FEDERAL COURT CAN ATTRIBUTE TO CONGRESS AN UNSTATED INTENT TO IMPOSE ON A STATE INCREASED FUNDING OBLIGATIONS UNDER THE MEDICAID ACT.

This Court has admonished lower federal courts that in applying statutory mandates, where the statute's singular language is plain, "the sole function of the court is to enforce it according to its terms." See United States v. Ron Pair Enterprises, Inc., 489 U.S. 235, 241 (1989) (quoting Caminetti v. United States, 242 U.S. 470, 485 (1917)). This Court has especially adhered to this rule in cases, such as that presented here, involving the imposition of conditions on a state under federal law in return for the state's receipt of federal funds. In such cases, this Court has insisted that before a state can be held responsible

for funding a claimed entitlement, it must be clear that Congress imposed such a condition "unambiguously," so that a state is not left "unaware of the [grant] conditions or is unable to ascertain what is expected of it." Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 17 (1981).

Applying these principles to this case, there is no basis for the district court's finding that a state has an "obligation" to make a disproportionate share payment that is "in the same ball park as the Medicare calculation would produce." App. 99a. Whatever "ball park" the district court may have imagined itself in as the umpire, rather than applying rules which have long been established by this Court, it simply composed and applied its own rules long after the game had commenced.

Consistent with its intention to give states flexibility and discretion in the manner in which they provide Medicaid reimbursement, Congress has permitted states to calculate the required additional disproportionate share payments either by adopting the formula for payments to disproportionate share hospitals used in the Medicare program or by developing their own formulae. See 42 U.S.C. § 1396r-4. States which develop their own formulae must provide for a "minimum specified additional payment amount" that is proportionate "to the percentage by which the hospital's Medicaid utilization rate ... exceeds one standard deviation above the mean medicaid inpatient utilization rate," 42 U.S.C. § 1396r-4(c)(2), or that is "reasonably related to the costs, volume, or proportion of services provided to

patients eligible for medical assistance." 42 U.S.C. § 1396r-4(c)(3)(B).

The district court here simply assumed that "Congress seem[ed] to have contemplated that the State's plan would produce comparable results" to Medicare in the setting of these payment amounts. App. 82a. Nothing in the law or legislative history reflects such contemplation. If Congress had intended a "ball park" level of compensation, it could easily have so expressed that requirement in the statute. Instead, Congress chose not to establish any minimum amount for disproportionate share payments in those instances where a state develops its own formulae and has provided no guidance beyond the statutory language in § 1396r-4 to assist a state in developing its own formula of payment. HCFA, the agency charged with interpreting the Medicaid Act, likewise

has not adopted any rules requiring this notion of comparability. Indeed, HCFA expressly approved the State's disproportionate share payment plan.[4] Thus the State, in reliance upon the plain language of the statute itself and on the explicit approval of its disproportionate share plan by HCFA, implemented those payments and otherwise planned, administered and funded its entire Medicaid Program.

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[4] Under such circumstances, the district court should have accorded great deference to HCFA's interpretation of 42 U.S.C. §1396r-4 in approving Pennsylvania's state plan amendment for disproportionate share payments. See, e.g., Chevron, Inc. v. Natural Resources Defense Council, 467 U.S. 837, 843 (1984); Gladstone, Realtors v. Village of Bellmead, 441 U.S. 91, 107 (1979).

The lower courts' judicially imposed funding requirement of comparability is also at odds with, and contrary to, recent congressional review of the disproportionate share concept. In October 1990, Senators Riegle and Chafee introduced a bill which would have for the first time imposed on the states "a uniform national minimum disproportionate share adjustment, equal at least to the amount of the adjustment that would result from using the Medicare adjustment formula" under section 1923(c) of the Act. See Senate Bill No. 3265 and Senator Riegle's comments at 136 Cong. Rec. S17866-17867 (October 27, 1990). That bill did not become law. Nevertheless, at respondents' urging, the courts below engrafted just such a requirement onto the otherwise plain language of section 1396r-4 of the Act,

thereby requiring Pennsylvania to pay disproportionate share adjustments at or near Medicare levels.

This Court should not countenance such judicial legislation, especially where, as here, the danger of permitting other courts to replicate such a precedent not only subverts congressional will but dramatically alters the nature of the bargain struck by Congress and the states under Medicaid's exercise in "cooperative federalism." As a participant in Medicaid, Pennsylvania has complied with, and funded, numerous major mandatory (as well as most optional) expansions of the program that have been passed by Congress between 1984 and 1990, which are set out in Appendix I to the GAO report, supra. As noted by the General Accounting Office, during this same period, Medicaid expenditures rose at an average annual rate of 10 percent

while total state revenues increased at a rate below 8 percent. See GAO Report No. HRD-91-78, reprinted in Medicare & Medicaid Guide (CCH) ¶ 39,495 at p. 27,357 (June 25, 1991). What this Court must address, consistent with its prior case law, is the imposition by judicial fiat of a mandate that Pennsylvania did not voluntarily and knowingly accept as a term of its contract with the federal government under the Medicaid program. This Court must not permit a lower court to attribute to Congress an unstated intent and so create an enforceable entitlement which compels a state to expend funds under a federal-state grant program where the state neither knew nor reasonably could have known that such an entitlement exists.

For all of these reasons, this Court should reject the district court's conclusions concerning disproportionate share payments, which were affirmed without specific discussion by the Court of Appeals.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for the writ of certiorari and, upon review, vacate or reverse the decision of the Court of Appeals.

INDEX TO APPENDIX

Filed July 30, 1991

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 90-1112

TEMPLE UNIVERSITY

Plaintiff - Appellee

v.

JOHN F. WHITE, JR.; EILEEN M. SCHOEN; DAVID S. FEINBERG; DAVID D. ULSH; G. JUNE HOCH

Defendants - Appellants

No. 90-1203

ALBERT EINSTEIN MEDICAL CENTER, ALLEGHENY GENERAL HOSPITAL, CHILDREN'S HOSPITAL OF PITTSBURGH, EPISCOPAL HOSPITAL, GIUFFRE MEDICAL CENTER, MAGEE-WOMENS HOSPITAL, MERCY CATHOLIC MEDICAL CENTER-MISERICORDIA DIVISION, MERCY HOSPITAL OF PITTSBURGH, MONTEFIORE HOSPITAL ASSOCIATION OF WESTERN PENNSYLVANIA, INC., PRESBYTERIAN UNIVERSITY HOSPITAL OF PITTSBURGH, ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, ST. JOSEPH'S HOSPITAL, ST. MARY HOSPITAL, WESTERN

PENNSYLVANIA HOSPITAL, GERMANTOWN HOSPITAL AND MEDICAL CENTER

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, HERSHOCK, MICHAEL H., as Secretary of the Budget

John F. White, Jr. and Michael H. Hershock,

Appellants

No. 90-1204

FRANKFORD HOSPITAL

v.

WHITE, JR., JOHN F., Secretary of Public Welfare, SCHOEN, EILEEN M., Deputy Secretary for Medical Assistance, Programs, FEINBERG, DAVID S., Director of the Bureau of Policy and Program Development of the Office of Medical Assistance, Programs, ULSH, DAVID D., Acting Director of the Division of Inpatient Programs of the Office of Medical Assistance Programs, and HERSHOCK, MICHAEL H., Secretary of the Budget

John F. White, Jr., Eileen M. Schoen, David S. Feinberg, David D. Ulsh and Michael H. Hershock,

Appellants

No. 90-1205

HAHNEMANN UNIVERSITY HOSPITAL and PRESBYTERIAN MEDICAL CENTER OF PHILADELPHIA, and THE TRUSTEES OF UNIVERSITY OF PENNSYLVANIA

v.

WHITE, JOHN F., JR., Secretary of Public Welfare, SCHOEN, EILEEN M., Deputy Secretary for Medical Assistance, FEINBERG, DAVID S., Director of the Bureau of Policy and Program Development of the Office of Medical Assistance, and ULSH, DAVID D., Acting Director of the Division of Inpatient Programs of the Office of Medical Assistance and HERSHOCK, MICHAEL H., Secretary of the Budget

John F. White, Jr., Eileen M. Schoen, David S. Feinberg, David D. Ulsh, and Michael H. Hershock,

Appellants

No. 90-1206

HOSPITAL ASSOCIATION OF PENNSYLVANIA; ALLEGHENY VALLEY HOSPITAL; THE ALLENTOWN HOSPITAL; ALLENTOWN OSTEOPATHIC MEDICAL CENTER; J.C. BLAIR MEMORIAL HOSPITAL; BRADDOCK GENERAL HOSPITAL; BRADFORD HOSPITAL;

BRANDYWINE HOSPITAL; BUTLER MEMORIAL HOSPITAL; CARBONDALE GENERAL HOSPITAL; CENTRAL MEDICAL CENTER AND HOSPITAL; CHAMBERSBURG HOSPITAL; CHESTER COUNTY HOSPITAL; CHESTNUT HILL HOSPITAL; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; CHARLES COLE MEMORIAL HOSPITAL; CLARION OSTEOPATHIC COMMUNITY HOSPITAL; CLEARFIELD HOSPITAL; COMMUNITY GENERAL OSTEOPATHIC HOSPITAL; COMMUNITY MEDICAL CENTER; CONEMAUGH VALLEY MEMORIAL HOSPITAL; DIVINE PROVIDENCE HOSPITAL; DIVINE PROVIDENCE HOSPITAL OF PITTSBURGH; DOYLESTOWN HOSPITAL; DUBOIS REGIONAL MEDICAL CENTER; EPHRATA COMMUNITY HOSPITAL; EVANGELICAL COMMUNITY HOSPITAL; EYE & EAR HOSPITAL OF PITTSBURGH; FORBES METROPOLITAN HEALTH CENTER; FORBES REGIONAL HEALTH CENTER; FRANKLIN REGIONAL MEDICAL CENTER; FRICK COMMUNITY HEALTH CENTER; GEISINGER MEDICAL CENTER; GEISINGER WYOMING VALLEY MEDICAL; THE GERMANTOWN HOSPITAL AND MEDICAL CENTER; GETTYSBURG HOSPITAL; GNADEN HUETTEN MEMORIAL HOSPITAL; GOOD SAMARITAN HOSPITAL; GREENE COUNTY MEMORIAL HOSPITAL; HAMOT MEDICAL CENTER; HANOVER GENERAL HOSPITAL; HARRISBURG HOSPITAL; HIGHLANDS HOSPITAL AND HEALTH CENTER; INDIANA HOSPITAL; HAMESON MEMORIAL HOSPITAL; JEANNETTE DISTRICT MEMORIAL HOSPITAL; JEFFERSON HOSPITAL; ANDREW KAUL MEMORIAL

HOSPITAL; KENSINGTON HOSPITAL; LANCASTER GENERAL HOSPITAL; LANKENAU HOSPITAL; LEE HOSPITAL; LEHIGH VALLEY HOSPITAL CENTER; McKEESPORT HOSPITAL; MEADVILLE MEDICAL CENTER; THE MEDICAL CENTER, BEAVER, PA., INC.; MEDICAL COLLEGE OF PENNSYLVANIA; MEMORIAL HOSPITAL; MEMORIAL HOSPITAL OF BEDFORD; MERCY CATHOLIC MEDICAL CENTER, FITZGERALD MERCY DIVISION; MERCY HOSPITAL, ALTOONA; MERCY HOSPITAL, SCRANTON; METHODIST HOSPITAL; MILLCREEK COMMUNITY HOSPITAL; MONONGAHELA VALLEY HOSPITAL; MUHLENBURG HOSPITAL CENTER; NESBITT MEMORIAL HOSPITAL; NORTHEASTERN HOSPITAL OF PHILADELPHIA; NORTH PENN HOSPITAL; OSTEOPATHIC MEDICAL CENTER OF PHILADELPHIA; PENNSYLVANIA HOSPITAL; PHOENIXVILLE HOSPITAL; POTTSTOWN MEMORIAL MEDICAL CENTER; POTTSVILLE HOSPITAL AND WARNE CLINIC; PUNXSUTAWNEY AREA HOSPITAL; THE PENN STATE HOSPITAL/THE MILTON S. HERSHEY MEDICAL CENTER; QUAKERTOWN COMMUNITY HOSPITAL; READING HOSPITAL AND MEDICAL CENTER; ROXBOROUGH MEMORIAL HOSPITAL; ST. AGNES MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST JOSEPH'S HOSPITAL, CARBONDALE; ST. JOSEPH HOSPITAL, LANCASTER; SACRED HEART HOSPITAL; SEWICKLEY VALLEY HOSPITAL; SHADYSIDE HOSPITAL; SHARON GENERAL HOSPITAL; THE SOUTH SIDE HOSPITAL; SOUTHERN CHESTER COUNTY MEDICAL CENTER; SUBURBAN GENERAL HOSPITAL; SUNBURY COMMUNITY

HOSPITAL; TAYLOR HOSPITAL; TYLER MEMORIAL HOSPITAL; TYRONE HOSPITAL; WESTMORELAND HOSPITAL ASSOCIATION; WILKES-BARRE GENERAL HOSPITAL; THE WILLIAMSPORT HOSPITAL & MEDICAL CENTER; and YORK HOSPITAL AND GREENVILLE REGIONAL HOSPITAL

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania;
HERSHOCK, MICHAEL H., in his official capacity only as Secretary of the Budget, Department of the Budget, Commonwealth of Pennsylvania;
FRANKLIN, CAROLYN, in her official capacity only as Western Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania;
HUGHES, PATRICIA, in her offical capacity only as Southeastern Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

John F. White, Jr., Carolyn Franklin, Patricia Hughes and Michael H. Hershock,

Appellants

No. 90-1244

TEMPLE UNIVERSITY

Plaintiff - Appellee

v.

JOHN F. WHITE, JR.; EILEEN M. SCHOEN; DAVID S. FEINBERG; DAVID D. ULSH; G. JUNE HOCH

Defendants - Appellants

No. 90-1661

HOSPITAL ASSOCIATION OF PENNSYLVANIA; ALLEGHENY VALLEY HOSPITAL; THE ALLENTOWN HOSPITAL; ALLENTOWN OSTEOPATHIC MEDICAL CENTER; J.C. BLAIR MEMORIAL HOSPITAL; BRADDOCK GENERAL HOSPITAL; BRADFORD HOSPITAL; BRANDYWINE HOSPITAL; BUTLER MEMORIAL HOSPITAL; CARBONDALE GENERAL HOSPITAL; CENTRAL MEDICAL CENTER AND HOSPITAL; CHAMBERSBURG HOSPITAL; CHESTER COUNTY HOSPITAL; CHESTNUT HILL HOSPITAL; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; CHARLES COLE MEMORIAL HOSPITAL; CLARION OSTEOPATHIC COMMUNITY HOSPITAL; CLEARFIELD HOSPITAL; COMMUNITY GENERAL OSTEOPATHIC HOSPITAL; COMMUNITY MEDICAL CENTER; CONEMAUGH VALLEY MEMORIAL HOSPITAL; DIVINE PROVIDENCE HOSPITAL; DIVINE PROVIDENCE HOSPITAL OF PITTSBURGH; DOYLESTOWN HOSPITAL; DUBOIS REGIONAL MEDICAL CENTER; EPHRATA COMMUNITY HOSPITAL; EVANGELICAL COMMUNITY HOSPITAL; EYE & EAR HOSPITAL OF PITTSBURGH; FORBES

METROPOLITAN HEALTH CENTER; FORBES REGIONAL HEALTH CENTER; FRANKLIN REGIONAL MEDICAL CENTER; FRICK COMMUNITY HEALTH CENTER; GEISINGER MEDICAL CENTER; GEISINGER WYOMING VALLEY MEDICAL CENTER; THE GERMANTOWN HOSPITAL AND MEDICAL CENTER; GETTYSBURG HOSPITAL; GNADEN HUETTEN MEMORIAL HOSPITAL; GOOD SAMARITAN HOSPITAL; GREENE COUNTY MEMORIAL HOSPITAL; HAMOT MEDICAL CENTER; HANOVER GENERAL HOSPITAL; HARRISBURG HOSPITAL; HIGHLANDS HOSPITAL AND HEALTH CENTER; INDIANA HOSPITAL; HAMESON MEMORIAL HOSPITAL; JEANNETTE DISTRICT MEMORIAL HOSPITAL; JEFFERSON HOSPITAL; ANDREW KAUL MEMORIAL HOSPITAL; KENSINGTON HOSPITAL; LANCASTER GENERAL HOSPITAL; LANKENAU HOSPITAL; LEE HOSPITAL; LEHIGH VALLEY HOSPITAL CENTER; McKEESPORT HOSPITAL; MEADVILLE MEDICAL CENTER; THE MEDICAL CENTER, BEAVER, PA., INC.; MEDICAL COLLEGE OF PENNSYLVANIA; MEMORIAL HOSPITAL; MEMORIAL HOSPITAL OF BEDFORD; MERCY CATHOLIC MEDICAL CENTER, FITZGERALD MERCY DIVISION; MERCY HOSPITAL, ALTOONA; MERCY HOSPITAL, SCRANTON; METHODIST HOSPITAL; MILLCREEK COMMUNITY HOSPITAL; MONONGAHELA VALLEY HOSPITAL; MUHLENBURG HOSPITAL CENTER; NESBITT MEMORIAL HOSPITAL; NORTHEASTERN HOSPITAL OF PHILADELPHIA; NORTH PENN HOSPITAL; OSTEOPATHIC MEDICAL CENTER OF PHILADELPHIA; PENNSYLVANIA HOSPITAL;

PHOENIXVILLE HOSPITAL; POTTSTOWN MEMORIAL MEDICAL CENTER; POTTSVILLE HOSPITAL AND WARNE CLINIC; PUNXSUTAWNEY AREA HOSPITAL; THE PENN STATE HOSPITAL/THE MILTON S. HERSHEY MEDICAL CENTER; QUAKERTOWN COMMUNITY HOSPITAL; READING HOSPITAL AND MEDICAL CENTER; ROXBOROUGH MEMORIAL HOSPITAL; ST. AGNES MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. JOSEPH'S HOSPITAL, CARBONDALE; ST. JOSEPH HOSPITAL, LANCASTER; SACRED HEART HOSPITAL; SEWICKLEY VALLEY HOSPITAL; SHADYSIDE HOSPITAL; SHARON GENERAL HOSPITAL; THE SOUTH SIDE HOSPITAL; SOUTHERN CHESTER COUNTY MEDICAL CENTER; SUBURBAN GENERAL HOSPITAL; SUNBURY COMMUNITY HOSPITAL; TAYLOR HOSPITAL; TYLER MEMORIAL HOSPITAL; TYRONE HOSPITAL; WESTMORELAND HOSPITAL ASSOCIATION; WILKES-BARRE GENERAL HOSPITAL; THE WILLIAMSPORT HOSPITAL & MEDICAL CENTER; and YORK HOSPITAL and GREENVILLE REGIONAL HOSPITAL

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania
HERSHOCK, MICHAEL H., in his official capacity only as Secretary of the Budget, Department of the Budget, Commonwealth of Pennsylvania
FRANKLIN, CAROLYN, in her official capacity only as Western Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

HUGHES, PATRICIA, in her official capacity only as Southeastern Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

John F. White, Jr., Carolyn Franklin, Patricia Hughes and Michael H. Hershock,

Appellants

On Appeal from the United States District Court for the Eastern District of Pennsylvania (D.C. Nos. 88-06646, 88-08831, 88-08927, 88-09132, 88-09848, 88-06646 and 88-09848)

Argued Thursday, January 10, 1991

BEFORE: COWEN, ALITO and GARTH, *Circuit Judges*

(Opinion filed July 30, 1991)

Ernest D. Preate, Jr.
Attorney General
Kate L. Mershimer, Senior
Deputy Attorney General
(argued)
Gwendolyn T. Mosley, Senior
Deputy Attorney General
Calvin R. Koons, Senior
Deputy Attorney General
John G. Knorr, III
Chief Deputy Attorney General,
Chief, Litigation Section
Office of Attorney General of
Pennsylvania

Strawberry Square
Harrisburg, PA 17120

William D. Lenahan,
Assistant Counsel, Department
of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105

Attorneys for Appellants
John F. White, Jr., Eileen M.
Schoen, David S. Feinberg and
David D. Ulsh

Matthew M. Strickler (argued)
Jenny P. Shulbank
Ballard, Spahr, Andrews
& Ingersoll

George E. Moore, Of Counsel
Temple University
Broad and Montgomery Avenue
Philadelphia, PA 19122

Attorneys for Appellee in
90-1112 and 90-1244

Jeffrey B. Schwartz
David M. Doret
Mark H. Gallant (argued)
Alan G. Rosenbloom
Wolf, Block, Schorr & Solis-Cohen
S.E. Corner 15th & Chestnut
Streets
Packard Building, 12th Floor
Philadelphia, PA 19102

Attorneys for Amicus
in 90-1112 and 90-1244 and
for Appellees in 90-1203

Jennifer A. Stiller (argued)
Elizabeth A. Read
Patrick K. McCoyd
Montgomery, McCracken, Walker
& Rhoads
Three Parkway - 20th Floor
Philadelphia, PA 19102

Attorneys for Appellees in
90-1204 and 90-1205

Roland Morris (argued)
Jack M. Mumford
Paula G. Sanders
Duane, Morris & Heckscher
The Payne Shoemaker Building
240 North Third Street
P.O. Box 1003
Harrisburg, PA 17108

Attorneys for Appellees in
90-1206

Henry W. Sawyer, III (argued)
James Eiseman, Jr.
Drinker Biddle & Reath
1100 Philadelphia National
Bank Building
Broad and Chestnut Streets
Philadelphia, PA 19107

Attorneys for Appellee
Sacred Heart Medical Center in
90-1661

OPINION OF THE COURT

GARTH, *Circuit Judge*:

This set of six consolidated appeals arises from the challenges, raised by over 140 Pennsylvania hospitals, to the validity of Pennsylvania's payment rates that the Commonwealth has set pursuant to its obligations under the Medicaid Program, Title XIX of the Social Security Act. 42 U.S.C.A. § 1396 *et seq.* (1983 & West Supp. 1991). The Medicaid Program, as it is described in *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1309 (2d Cir. 1991), "establishes a joint federal and state cost-sharing system to provide necessary medical services to indigent persons who otherwise would be unable to afford such care."

Because Pennsylvania participates in the Medicaid Program, it must comply with the federal statutory and regulatory scheme which requires, among other things, that a participating state establish a Medical Assistance Program, ("MAP"), pursuant to which it pays hospitals for their inpatient treatment of Medicaid patients. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2513 (1990). The hospitals involved in these appeals all claim that Pennsylvania's 1988-1989 payment rates were inadequate to meet the substantive standards of Title XIX, and that the method by which the Commonwealth promulgated those rates did not comply with the requirements of that statute. Accordingly, the plaintiff hospitals argue that Pennsylvania's MAP, which established the 1988-1989 rates, must be voided.

I

Temple University, ("Temple"), brought this § 1983 action in August of 1988, alleging that the Pennsylvania Department of Public Welfare, ("DPW"), was depriving Temple University Hospital of rights secured by Title XIX, 42 U.S.C.A. § 1396 *et seq.*, and the regulations thereunder.[1] Following a bench trial, the district court issued an opinion on January 24, 1990, holding that: (1) the Pennsylvania MAP payment rates were arbitrary because the procedure by which DPW grouped the hospitals for rate classification was unrelated to the efficiency or economy of the hospitals, and because Pennsylvania's across-the-board "budget neutrality" cut was entirely budget-driven and not justifiable; (2) the 2.5% add-on that DPW granted Temple for its status as a disproportionate-share hospital[2] was inadequate in light of the federal statutory requirement that Pennsylvania's MAP take into account the special circumstances of hospitals treating a disproportionate number of low-income patients; and (3) the process by which DPW adopted its MAP and rates did not comply with the federal statutory and regulatory

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1. Any doubt that § 1396a(a)(13)(A) creates rights enforceable under § 1983 was laid to rest by the Supreme Court's ruling in *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990). *Wilder* held, among other things, that § 1983 does provide a cause of action for the substantive rights established in § 1396a(a)(13)(A).

2. A disproportionate-share hospital is one that, pursuant to statute, is entitled to receive additional payments because of its service to a disproportionate number of low income patients. *See infra* § II B (citing 42 U.S.C.A. § 1396r-4(b) (West Supp. 1991)).

requirements mandating that each participating state make meaningful findings as to the reasonableness and adequacy of the rates established and as to the State's add-ons for a hospital's disproportionate-share status. *See Temple University v. White*, 729 F. Supp. 1093, 1096-1101 (E.D. Pa. 1990). The district court accordingly ordered DPW to bring the Pennsylvania MAP into conformity with federal requirements, and ordered further briefing as to the appropriate level of interim payments pending modification of the MAP. *Temple*, 729 F. Supp. at 1101.

On February 21, 1990, the district court awarded interim relief to Temple to mitigate the irreparable loss that Temple would otherwise suffer pending DPW's development of a new MAP. *Temple University v. White*, 732 F. Supp. 1327, 1328 (E.D. Pa. 1990). The district court established the interim payment rate by restructuring the group into which Temple had been placed to include only the seven most similar hospitals. The court also reduced the arbitrary "budget neutrality" adjustment from 14% to 2.4%, and raised the disproportionate share add-on to 10%. *Id.* at 1328-29. The district court ordered that "pending final revision of its Medicaid plan . . . [DPW] shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09." (App. 31).[3] *See also Temple*, 732 F.

3. Citations to "(App.)" refer to the Appendix filed with this court by the appellants on March 26, 1990. Citations to "(Supp. App.)" refer to the Supplemental Appendix filed by the appellants on May 9, 1990. Citations to "(SH App.)" refer to the Appendix filed in case No. 90-1661, in relation to the award of emergency relief to Sacred Heart Hospital. *See infra* § V. Citations to "(SH Supp. App.)" refer to the Supplemental Appendix filed by the Appellees along with their brief in No. 90-1661 on November 21, 1990.

Supp. at 1329. The district court did not require Temple to post a bond because of the ongoing relationship between the parties and the ability of DPW to recapture any excessive payments through reductions in future payments, if necessary. *Id.*

Meanwhile, the other hospitals involved in this appeal had filed similar suits against DPW, seeking essentially the same relief as Temple had sought. The district court entered its January 24 and February 21, 1990 orders in the Temple case while those cases were pending. Subsequently, the other hospitals filed various motions for interim relief, and, on March 1, 1990, the district court entered an order granting relief in each of those pending cases.[4] The court granted relief "for the reasons stated in this court's rulings on interim relief in [*Temple*] (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features)." *See supra* note 4. The orders required DPW to apply a rate calculation in its payments to the hospitals that did not include any "budget neutrality" adjustment in excess of 2.4%, *id.*, the amount the court imposed in the *Temple* case after invalidating the 14% across-the-board cut as being arbitrary and solely budget-driven. 732 F. Supp. at 1328-29.

Subsequently, in August, 1990, while these cases were pending on appeal, Sacred Heart

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4. *Albert Einstein Medical Center v. White*, 732 F. Supp. 1329 (E.D. Pa. 1990); *Frankford Hosp. v. White*, unpublished order, No. 88-8927 (E.D. Pa. March 1, 1990); *Hahnemann University Hosp. v. White*, unpublished order, No. 88-9132 (E.D. Pa. March 1, 1990); *Hosp. Ass'n of Pennsylvania v. White*, unpublished order, No. 88-9848 (E.D. Pa. March 1, 1990). The district court entered an identical order in each of these cases. See *infra* note 14 for the full text of these orders.

Hospital, a party to the *Hospital Association of Pennsylvania* case, filed an application with the district court, seeking emergency relief. Sacred Heart sought a $2 million advance from DPW against amounts expected as future payments for medical assistance under the MAP that DPW had been directed to promulgate. At the close of an August 14, 1990 hearing, the district court granted relief to Sacred Heart by entering a preliminary injunction requiring DPW to advance to Sacred Heart a total of $2 million to be paid in installments of $500,000, beginning ten days after the date of its Order and continuing thereafter at 30-day intervals. Transcript of Hearing of August 14, 1990 at 139; (SH App. 155). On October 5, 1990, the district court denied DPW's motion for a stay of this injunctive relief. *See Hosp. Ass'n of Pennsylvania v. White*, Unpublished Order, No. 88-9848 (E.D. Pa. October 15, 1990); (SH Supp. App. 3-6).[5]

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5. After oral argument, but before the filing of this opinion, we were informed that the parties had executed and filed, with the district court, a comprehensive document entitled "Stipulation of Settlement." In addition, Sacred Heart informed us that a special agreement had been entered into and filed with respect to its appeal at No. 90-1661. Supplemental submissions were then filed by the parties with this court addressed to the issue of possible mootness. We were advised of the highly conditional nature of the settlement, *see Coopers & Lybrand v. Livesay*, 437 U.S. 463, 465 n.3 (1978), and were furnished with copies of the Stipulation of Settlement and the special Sacred Heart agreement.

We have supplemented the record on these appeals with these documents, and we have noted the various obligations placed upon the parties, compliance with which is required for each of the fiscal years, to and including June, 1993, at which date, if all terms have been met, the parties have agreed that the actions be dismissed. Prior to that time,

II

A

The Medicaid law, Title XIX of the Social Security Act, 42 U.S.C.A. § 1396 *et seq.*, authorizes federal financial support to states providing medical assistance to certain low income persons. In Pennsylvania, the federal financial contribution amounts to 56% of the costs of covered services. *Temple*, 732 F. Supp. at 1327-28.[6] Participation in Medicaid is optional, but once a state elects to participate, it must comply with all federal statutory and regulatory requirements. *Wilder*, 110 S. Ct. at 2513; *Harris v. McCrae*, 448 U.S. 297, 301 (1980).

States have historically paid hospitals the actual costs incurred in providing care to Medicaid recipients, regardless of disparities in costs or efficiencies among the respective hospitals. In 1981, Congress enacted the "Boren Amendment,"

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the Stipulation contemplates that DPW will make payments to the hospitals that exceed those which are required by the district court orders we review here.

We are satisfied that these appeals have not been mooted by the Stipulation and agreements of the parties, *see, e.g.*, Stipulation of Settlement p. 33, ¶ 6.5, and that disposition of the instant appeals should be had on the merits. *See Coopers & Lybrand*, 437 U.S. at 465 n.3. We, of course, express no view concerning the approval of the Stipulation of Settlement and the Sacred Heart agreement by the district court, inasmuch as neither the terms of the agreements nor their approval are the subjects of appeal before us.

6. See *West Virginia University Hosp. v. Casey*, 885 F.2d 11, 15 (3d Cir. 1989), *aff'd in part*, 111 S. Ct. 1138 (1991) (Court reviewed and affirmed only an issue as to attorneys' fees) [hereinafter "*WVUH*"], for a more detailed overview of Title XIX.

see 42 U.S.C.A. § 1396a(a)(13)(A), which substituted for this mandatory "reasonable cost reimbursement" system the requirement that states must at least provide payments to hospitals:

> through the use of rates (determined in accordance with methods and standards developed by the State . . . and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State *finds*, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality[.]

42 U.S.C.A. § 1396a(a)(13)(A) (emphasis added).

To qualify for federal funding, a state must submit a state plan - a MAP - for approval by the Health Care Financing Administration ("HCFA"), of the Department of Health and Human Services. 42 C.F.R. § 447.200 (1990). The MAP must "specify comprehensively the methods and standards used by the agency to set payment rates," 42 C.F.R. § 447.252(b); provide for the payment of rates which the state "finds" are "reasonable and adequate" to "meet the costs that must be incurred by economically and efficiently operated facilities," 42 C.F.R. § 447.253(b); and contain "assurances" to HCFA that this standard has been satisfied. 42

C.F.R. § 447.253(a). HCFA relies on the state's "assurances" and does not independently evaluate the adequacy of the rates. At least annually, a state must make "findings" that assure the "reasonableness and adequacy" of its inpatient hospital rates. 42 C.F.R. § 447.253(b). It must also make findings "[w]henever the Medicaid agency makes a change in its methods and standards." *Id.*

B

Through the fiscal year ending on June 30, 1984, the Pennsylvania MAP reimbursed hospitals based on their actual costs. In 1984, DPW, relying on the Boren Amendment, promulgated a revised MAP that provided for a change to a prospective payment system. (Supp. App. 446a).[7] Under that system, the operating costs of most acute care inpatient hospital stays are reimbursed by a flat payment per discharge that is a multiple of the hospital's "payment rate" and a "relative value" assigned to the diagnostic related group ("DRG") into which the particular case falls.

A hospital's payment rate depends on its peer "Group" category. DPW ranks all general hospitals (with the exception of children's hospitals), into seven approximately equally sized Groups based upon weighted ratings in each of four categories with the aim of roughly aligning hospitals with similar characteristics. *See* (Supp. App. 498a-501a). Each children's hospital comprises its

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7. See *WVUH*, 885 F.2d at 15-16 and *Temple University v. White*, 729 F. Supp. 1093, 1095-99 (E.D. Pa. 1990), for a more detailed description of Pennsylvania's prospective payment system.

own Group. Hospitals in Groups 1 and 2 and children's hospitals treat the largest volume of Medicaid recipients in the Commonwealth, and are, therefore, the most heavily dependent on MAP revenues to meet operating costs. (Supp. App. 603a-04a). Group payment rates are based on the weighted group average cost per case within each group that DPW derives through a detailed computation. (App. 60-62); *Temple*, 729 F. Supp. at 1097.

Some hospitals also receive additional payments because of their service to a disproportionate number of low income patients. Pursuant to the statutory requirements, 42 U.S.C.A. § 1396r-4(b), DPW identified these disproportionate-share status hospitals, then arranged these hospitals into five groups defined by the percentage of their total days devoted to federally funded medical assistance patients. Hospitals in these five disproportionate share groups receive additional payments of .5%, 1%, 1.5%, 2%, or 2.5% above their regular payment rates.

For 1984, the first year that the prospective payment plan was operative, DPW structured the system to be "budget neutral," and applied an adjustment factor to limit aggregate payments to an estimate of what the old system's payments would have been. (Supp. App. 465a). After the regrouping of hospitals into their assigned groups pursuant to DPW's 1988-1989 MAP, DPW reduced the group average rates for all Groups by a uniform factor of approximately 14% to effect what DPW called a "budget neutrality adjustment." This 14% "lop off," (Supp. App. 568a-69a, 572a), was designed to restrict total MAP payments to the

respective hospitals to the amount of the total inpatient budget appropriation for 1988-1989.[8]

III

Title XIX requires states to set rates "which the State *finds*, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities. . . ." 42 U.S.C.A. § 1396a(a)(13)(A) (emphasis added). We held, in *WVUH*, that the federal regulations implementing § 1396a(a)(13)(A) "unambiguously require the State to make findings" to support its Medicaid plan. 885 F.2d at 30.[9] In so holding, we determined that

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8. By applying the 14% budget neutrality adjustment, the budget was reduced to $427 million from $497 million, the budget amount that otherwise would have been available. (App. 505); (Supp. App. 646a).

9. Federal regulations specify that:

> (b) *Findings*. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> (1) *Payment Rates*. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
>
> (ii) With respect to inpatient hospital services-
>
> (A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. . . .

42 C.F.R. § 447.253(b) (1990).

Pennsylvania was not in compliance with the federal statute and regulations because it admitted to gathering no information as to the out-of-state hospitals' actual costs, and did no empirical analysis to measure the effects of the payment program on those hospitals and thus made none of the requisite findings. *Id.* at 30. The Supreme Court recently took note of this "findings" requirement in *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2519 & n.11 (1990). In response to an argument that Title XIX merely required that a state provide assurances to the Secretary that its rates comply with the statute, the Court emphasized that such an argument "ignores the language of the statute that requires a State to *find* that its rates" comply with the reasonable and adequate requirement, and that such findings are "a necessary prerequisite to the subsequent requirement that the State provide 'assurances' to the Secretary." *Id.* at 2519 n.11 (emphasis in original).[10] We review the issue of a state's compliance with Title XIX's procedural requirements under a plenary standard. *See WVUH*, 885 F.2d at 29-30.

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10. *See also AMISUB v. State of Colorado Dep't of Social Services*, 879 F.2d 789, 796 (10th Cir. 1989) (holding that "[t]he plain language of federal Medicaid law mandates the State Medicaid Agency, *at a minimum*, to make 'findings' which identify and determine (1) efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and, (3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals.") (emphasis in original), *cert. denied*, 110 S. Ct. 3212 (1990); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1294 (8th Cir. 1985) (state must conduct objective analysis or study to support its findings and assurances), *cert. denied*, 479 U.S. 1063 (1987).

More recently, the Second Circuit, in *Pinnacle Nursing Home*, addressed the procedural requirements of the Boren Amendment in the same context as we do here. 928 F.2d at 1313-14. The language of the *Pinnacle* opinion, referring to the need for findings, bears repetition:

> We decline the state's invitation to read the procedural requirements of the Boren Amendment as mere surplusage. The Supreme Court recently dispelled this notion, reconfirming that the procedural requirements of the Boren Amendment were intended to be observed. . . . In light of the abundant evidence demonstrating that Congress intended that the procedural requirements be followed, the state's argument that "findings" are not mandatory is fatally flawed. That conclusion is reinforced by the mandatory, rather than precatory, language of the statute itself. 42 U.S.C. § 1396a(a)(13)(A) ("[a] State plan for medical assistance *must*" provide for payment of rates which the state *finds* are reasonable and adequate (emphasis added)). Although procedural requirements may reduce some of the state's "flexibility" in determining their own schemes of reimbursement, this is what the plain language of the statute requires.

Pinnacle Nursing Home, 928 F.2d at 1313-14.[11]

In the present case, then, DPW was required to

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11. *Pinnacle* dealt with nursing homes that challenged adjustments made by the State of New York in connection with Medicaid reimbursements. Among other things, the Court of Appeals held that the adjustments to the Medicaid reimbursement plan were invalid because no findings were made which established a nexus between the cost of operating efficient and economical nursing facilities and the proposed reimbursement rates. *Pinnacle Nursing Home*, 928 F.2d at 1314-15.

find that its MAP complied with the three substantive requirements of § 1396a, *i.e.*, that (1) its rates take into account the circumstances of hospitals serving a disproportionate share of low-income patients; (2) its "rates are reasonable and adequate to meet the necessary costs of an efficiently operated hospital;" and (3) its rates are reasonable and adequate "to assure medicaid patients of reasonable access to inpatient hospital care." *WVUH*, 885 F.2d at 22.

The district court, however, found that DPW made no findings based upon empirical studies "on such matters, for example, as the characteristics of an efficient and economical hospital operation, the impact of the proposed reimbursement rates upon hospitals' ability to survive, etc. – but merely certified that its plan complied with the statutory requirements." *Temple*, 729 F. Supp. at 1100. DPW's study or investigation of its rate structure was limited to a few internally-generated reports that show which hospitals reported costs above or below the group rates and to some revenue projections indicating that, after the regrouping of the hospitals and the recalculation of the rates, the projected revenues of some of the hospitals went up and the projected revenues of the other hospitals went down. (App. 327-29). DPW also took note of the fact that it had not received complaints about the inability of medical assistance recipients to obtain care. (App. 328).

Thus, DPW had conducted no analysis and had made no findings as to the reasonableness or adequacy of its rates to cover the costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and

varying percentage add-ons for disproportionate-share hospitals. Nor did DPW identify any findings which it made pertaining to "reasonable access to inpatient hospital care." Indeed, DPW admitted as much during pretrial discovery. Temple posed the following interrogatory:

> Identify any studies performed, findings prepared, or investigations conducted by DPW referring or relating to or evidencing the adequacy and reasonableness of the M.A. Program's inpatient hospital rates relative to costs for Fiscal Year 1989 (using Fiscal Year 1987 claims paid data Trended Forward for Inflation and without a Budget Neutrality Adjustment).

(App. 611). DPW's answer was:

> No special studies, findings, or investigations were conducted by DPW referring or relating to or evidencing the adequacy and reasonableness of the MA Program's inpatient hospital rates relative to costs for FY 1989 (using FY 1987 claims paid data trended forward for inflation and without a Budget Neutrality Adjustment).

Id. DPW's failure to assemble information in making its decisions as to rates is reflected in the testimony of David Feinberg, an administrator in DPW responsible for "all medical assistance policy and other activities related to all inpatient hospital and outpatient providers who participate in medical assistance programs." (App. 298). Mr. Feinberg stated that "[w]e don't know, today, what hospital costs are. They have not been audited, so we don't know how close anybody is to [the various group rates]." (App. 312).

Without knowledge of hospital costs, DPW could not have known what an efficient and economical hospital operation would entail, let alone what payment rates would be reasonable and adequate to meet that hospital's costs and assure reasonable access to hospital care. In the absence of essential data and information, DPW was in no position to make findings, and clearly did not do so. Any assurances DPW made to the Secretary were, therefore, without foundation. Accordingly, as the district court held, DPW's MAP was not in compliance with federal law, specifically, § 1396a(a)(13)(A) and 42 C.F.R. § 447.253(b), as interpreted by our court and by the Supreme Court. *See WVUH*, 885 F.2d at 29-30; *Wilder*, 110 S. Ct. at 2519 & n.11.[12]

The lack of critical and required findings mandates that we affirm the district court's holding that DPW's 1988-1989 MAP was invalid, and that DPW must promulgate a new MAP that complies with the procedural and substantive provisions of Title XIX. In accordance with the remedy that we afforded to West Virginia University Hospital, "[r]eimbursement to [Temple] under a prospective payment system that conforms to federal law will commence with the date of the district court's initial judgment in this matter."

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12. At oral argument, counsel for DPW insisted repeatedly that DPW had made findings in compliance with this requirement. Despite persistent questioning from the court, however, counsel failed to point to a single specific finding in the record that would satisfy DPW's obligations. Neither have we found such a finding in the documents and testimony to which counsel referred us on this point. *See, e.g.*, Transcript of Oral Argument of January 10, 1991 at 6-16. *See also id.* at 82. Counsel subsequently conceded outright that DPW had no "written findings." *Id.* at 86.

WVUH, 885 F.2d at 35. Any adjustment that becomes necessary as to the amount of the payments to be made to Temple pursuant to the district court's injunction is to be made either through additional DPW payments to Temple or by DPW's recoupment in future payments of any overpayments.

IV

A

DPW challenges the "interim" injunctive relief that the district court awarded to Temple in its February 21, 1990 order,[13] and to the other hospitals, (hereinafter referred to as "Hospitals"), in its March 1, 1990 orders.[14] As an initial matter,

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13. The injunctive relief ordered by the district court in its February 21, 1990 order reads as follows:

> AND NOW, this 21st day of February, 1990, it is ORDERED:
>
> That, pending final revision of its Medicaid plan in conformity with this court's Memorandum and Order of January 24, 1990, the defendants shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09.
>
> IT IS FURTHER ORDERED that if it is later finally determined, either in this litigation or in the implementation of an acceptable revised medical assistance plan, that the amounts received by plaintiff pursuant to this Order are excessive, plaintiff shall promptly refund the excess, either by payment or by credit against future entitlement.

(App. 31).

14. The order which the district court entered in each of the Hospitals' pending cases on March 1, 1990 reads as follows:

> AND NOW this 1st day of March, 1990, upon consideration of the various pending applications for

DPW claims that the district court's orders providing interim injunctive relief are invalid because the district court erred in its liability determinations, which, as to Temple, were expressed in the district court's January 24, 1990 opinion, *Temple*, 729 F. Supp. 1093, and, as to the Hospitals, were expressed in the district court's March 1, 1990 orders. *See supra* note 14. We have earlier discussed the district court's merits/liability holding in *Temple*, and we are satisfied that the district court did not err in its analysis or in its holding that DPW did not meet the "findings" requirements of 42 U.S.C.A. § 1396a. *See supra* § III. DPW, as noted above, however, also challenges that holding as it applies to the Hospitals.

> interim relief, and for the reasons stated in this court's rulings on interim relief in the case of *Temple University v. John F. White, Jr.*, C.A. 88-6646 . . . (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:
>
> 1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.
>
> 2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

Albert Einstein Medical Center v. White, 732 F. Supp. 1329 (E.D. Pa. 1990). *See also Frankford Hosp. v. White*, unpublished order, No. 88-8927 (E.D. Pa. March 1, 1990), *reproduced in*, (Supp. App. 30a); *Hahnemann University Hosp. v. White*, unpublished order, No. 88-9132 (E.D. Pa., March 1, 1990), *reproduced in*, (Supp. App. 34a); *Hosp. Ass'n of Pennsylvania v. White*, unpublished order, No. 88-9848 (E.D. Pa. March 1, 1990), *reproduced in*, (Supp. App. 38a).

Because the district court subsumed in its March 1 order the merits holding which it had reached in *Temple*, DPW is correct when it argues that the Hospitals have received the benefit of the Temple merits determination without having been parties to the Temple proceeding or the Temple trial. DPW is not correct, however, in its assertion that the reasons given in the district court's January 24, 1990 merits opinion, as they pertain to Temple, do not extend to the Hospitals.

In this connection, the Hospitals call our attention to the doctrine of collateral estoppel. We have noted that this doctrine may be invoked where:

> (1) The issue decided in the prior adjudication was identical with the one presented in the later action;
>
> (2) There was a final judgment on the merits;
>
> (3) The party against whom the plea is asserted was a party or in privity with a party to the prior adjudication; and
>
> (4) The party against whom it is asserted has had a full and fair opportunity to litigate the issue in question in the prior action.

Gregory v. Chehi, 843 F.2d 111, 121 (3d Cir. 1988) (citations omitted). *See also Parklane Hosiery v. Shore*, 439 U.S. 322, 324, 326-33 (1979) (recognizing legitimacy of nonmutual offensive collateral estoppel as applied to give preclusive effect to previous federal court judgment).[15] DPW

15. DPW has not argued that the doctrine of collateral estoppel is inapplicable in this case. Indeed, no argument refuting the Hospitals' theory appears in DPW's briefs.

does not dispute that the issues raised by the hospitals in their related cases were raised, actually litigated, and decided against DPW in the *Temple* case. Neither does DPW dispute that it had a full and fair opportunity to litigate those issues nor that the decision rendered on those issues in *Temple* constituted a valid and final judgment on the *Temple* merits. Nor can it be argued that the determination of each of the issues contested in *Temple* was not essential to the district court's judgment. Because each of the elements required for the application of collateral estoppel or issue preclusion was satisfied, and because the invalidation of Pennsylvania's MAP necessarily affected the hospitals in Pennsylvania, we are persuaded that DPW's challenge to the March 1 orders as they pertain to the district court's liability determination voiding Pennsylvania's MAP, is meritless.[16]

We recognize, of course, that the March 1 orders which were entered to give relief to the Hospitals did not attempt to categorize each of the Hospitals by group or classification. Indeed, in these orders, the district court expressly disclaimed any such analysis when it granted relief "for the reasons

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16. While the district court did not explicitly base its order on the doctrine of collateral estoppel, it implied as much by basing its interim award on "the reasons stated in this court's rulings on interim relief in [*Temple*] (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features). . . ." *See supra* note 14. We review a district court's application of the doctrine of collateral estoppel only for abuse of discretion. *McLendon v. Continental Can*, 908 F.2d 1171, 1177 (3d Cir. 1990). In the context of the district court's rulings which we have reviewed and sustained and the district court's analyses, the district court did not abuse its discretion.

stated in this court's rulings on interim relief in the case of *Temple University v. John F. White, Jr.*, C.A. 88-6646 . . . (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features. . . .)." *See supra* note 14. Rather, the thrust of the March 1 orders was to reduce the budgetary adjustment from the arbitrary across-the-board 14% assessed by DPW, to a percentage not to exceed 2.4%. This ruling, based on collateral estoppel, *see supra* note 16, followed from the district court's analysis in *Temple* of the budget neutrality adjustment. *Temple*, 729 F. Supp. at 1098-99; *Temple*, 732 F. Supp. at 1328.

Having concluded that DPW had not complied with the federal statute and regulations governing its participation in the Medicaid Program and that the district court's orders to that effect extended not only to Temple but to the Hospitals, as well, we are satisfied that Temple and the Hospitals properly prevailed on the merits of their challenges to DPW's MAP, and, therefore, that they have met the threshold requirement for an award of injunctive relief against DPW. We turn, therefore, to DPW's remaining challenge to the "interim" injunctive relief which the district court ordered to remedy DPW's violation of Title XIX.

B

The district court styled the remedy in its February 21 and March 1 orders as "interim relief," despite the fact that they followed a final determination of liability, i.e., a holding that DPW had violated Title XIX, and despite the fact that the relief ordered partakes of all the characteristics

of a permanent injunction.[17] The parties, DPW on the one hand, and Temple and the Hospitals on the other, have argued that the character of the district court's February 21 and March 1 orders is significant because a difference exists in the standards by which a preliminary injunction and a permanent injunction are tested.

DPW claims that the orders at issue are preliminary injunctions and, as such, that irreparable injury had to be shown in order for the district court to enter its decrees. Moreover, DPW contends that, because no irreparable harm was found by the district court, its decrees cannot be sustained. *See Bill Blass Ltd. v. Saz Corp.*, 751 F.2d 152, 154 (3d Cir. 1984). Temple and the Hospitals counter this argument by claiming that the district court's orders constituted permanent injunctions and that as such irreparable harm need not be demonstrated. *See Ciba-Geigy v. Bolar Pharmaceutical*, 747 F.2d 844 (3d Cir. 1984). *But see Natural Resources Defense Council v. Texaco*, 906 F.2d 934, 941 (3d Cir. 1990).

While we have no difficulty in identifying the injunctive relief at issue here as permanent in nature, *see supra* note 17, we are, however, aware that different views have been expressed from time to time as to the need for establishing irreparable harm as a predicate to the entry of a permanent

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17. While we have acknowledged that the district court itself referred to the injunctive relief which it ordered as "interim," we read and understand the district court's orders as being "interim" only to the extent that the district court ordered a new MAP to be promulgated, and that the injunctive relief ordered was to continue in force until the new MAP became effective. We do not regard the characterization of "interim" relief as being synonymous with preliminary injunctive relief in the context in which this case has developed.

injunction.[18] Even if we could resolve an apparent conflict as to whether a permanent injunction requires the showing of irreparable injury, *compare*

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18. *Compare, e.g., Rondeau v. Mosinee Paper Corp.*, 422 U.S. 49 (1975) (although plaintiff prevailed on merits as to violation of Williams Act, absence of traditional showing of irreparable harm rendered permanent injunction unavailable); *Natural Resources Defense Council*, 906 F.2d at 941 ("[A] district court may issue a permanent injunction . . . *only* after a showing both of *irreparable injury* and inadequacy of legal remedies, and a balancing of competing claims of injury and the public interest.") (emphasis added) *with, e.g., Roe v. Operation Rescue*, 919 F.2d 857, 867 n.8 (3d Cir. 1990) (enumerating requirements for permanent injunctive relief, and not including irreparable harm among those requirements); *Ciba-Geigy*, 747 F.2d at 850 (where district court has correctly found that plaintiff has succeeded on the merits, court of appeals "must uphold the permanent injunction in its entirety so long as the balance of equities favors injunctive relief"); 11 Wright & Miller, Federal Practice and Procedure § 2944, at 399-401 & n.41 (1973 & West Supp. 1991) ("[I]rreparable injury is not an independent requirement for obtaining a permanent injunction; it is only one basis for showing the inadequacy of the legal remedy.").

See also Lewis v. S.S. Baune, 534 F.2d 1115, 1123-24 (5th Cir. 1976) ("In not all cases where petitioner fails to show irreparable injury will he still be denied a *permanent* injunction.") (emphasis in original); *K-Mart Corp. v. Oriental Plaza*, 875 F.2d 907, 914-15 (1st Cir. 1989) (for both preliminary and permanent injunction, requirements include a showing of irreparable harm, but "[t]he necessary concomitant of irreparable harm is the inadequacy of traditional legal remedies. . . . [I]f money damages will fully alleviate harm, then the harm cannot be said to be irreparable."); *New York State National Organization for Women v. Terry*, 886 F.2d 1339, 1362 (2d Cir. 1989) ("Generally, to obtain a permanent injunction a party must show the absence of an adequate remedy at law and irreparable harm if the relief is not granted.") (citing *Rondeau*, 422 U.S. at 57), *cert. denied*, 110 S. Ct. 2206 (1990).

Roe, 919 F.2d at 867 n.8 *with Natural Resources Defense Council*, 906 F.2d at 941, and obviously we cannot,[19] we, nevertheless, can proceed with our analysis because irreparable harm is reflected throughout the present record. Our disinclination to enter this thicket is prompted most importantly by the fact that, regardless of any distinction between the requirements for preliminary injunctions and permanent injunctions, and regardless of differing requirements found in our permanent injunction cases as to irreparable injury, the record here amply demonstrates the presence of irreparable harm.

C

The order entered by the district court on January 24, 1990, 729 F. Supp. at 1101, upon which all subsequent orders were based, was an injunctive order directing DPW to revise its MAP so that it would comply with all federal requirements. That order, consistent with the district court's opinion of that date, voided the MAP under which DPW had theretofore been operating. 729 F. Supp. 1093. Hence, as of

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19. Our Internal Operating Procedures provide that:

> It is the tradition of this court that the holding of a panel in a reported opinion is binding on subsequent panels. Thus, no subsequent panel overrules the holding in a published opinion of a previous panel. Court in banc consideration is required to do so.

Third Circuit I.O.P. 9.1. *See also* I.O.P. Intro. § A(2) (I.O.P.'s are designed to "insure decisional stability and avoid intra-circuit conflict of decisions by . . . [providing] that a holding of a published opinion of the court may not be overruled without the approval of a majority of the in banc court[.]").

January 24, 1990, no MAP was in place which could provide for any payments, regardless of amount, to Temple or to the Hospitals.[20]

While under other circumstances DPW's argument that "none of the Hospitals had established that they would close their doors without interim relief,"[21] might be persuasive, that argument fails here where Pennsylvania's MAP has been invalidated. Without an approved State plan, there can be no approved rates and, therefore, no payments available to be made by DPW to the hospitals. *See supra* note 20 (citing 42 C.F.R. § 447.253(g)). This consideration undoubtedly prompted the district court to find, in its February 21, 1990 opinion, that "it is appropriate to grant interim relief to mitigate irreparable loss which the plaintiff would otherwise suffer, pending final action on a revised plan." 732 F. Supp. at 1328.

Thus, whether or not irreparable injury is a requirement for a permanent injunction, the stark fact is that, in the present proceedings, irreparable injury and harm to the hospitals was threatened and became implicit the moment that the district court invalidated Pennsylvania's 1988-1989 MAP. At that point, as we have noted, no further authority existed for payments to the hospitals, thereby depriving Temple and the Hospitals, to the

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20. The federal regulations governing state payments include the following section:

> (g) *Rates paid.* The Medicaid agency *must pay* for inpatient hospital and long term care services using rates determined *in accordance with methods and standards specified in an approved State plan.*

42 C.F.R. § 447.253(g) (emphasis added).

21. Supplemental Brief of DPW, at 20.

extent that the *Temple* holding applies to them, of Pennsylvania's participation in its funding.

Indeed, the district court, in its February 21, 1990 opinion had observed that 44% of the Medicaid costs were the responsibility of Pennsylvania, with the remaining 56% the responsibility of the federal government. *Temple*, 732 F. Supp. at 1327-28. While we know of no case where the invalidation of a state plan resulted in a complete cessation of payments to the affected hospitals, the thrust of the Medicaid statute, 42 U.S.C.A. § 1396 *et seq.*, would indicate that, absent compliance by a participating state, the inevitable consequence might well be a collapse of such funding. In such circumstances, where Medicaid funding is endangered, we would be hard-pressed not to sustain the finding of the district court that Temple and the Hospitals would suffer irreparable harm, if such a showing were indeed required for the issuance of a permanent injunction.

The other elements to be considered in decreeing a permanent injunction consist of a showing of success on the merits, the inadequacy of legal remedies, and a balancing of competing claims of injury and the public interest. *See, e.g., Natural Resources Defense Council*, 906 F.2d at 938, 941; *Roe* 919 F.2d at 867 n.8. Each of these factors is satisfied in this case. As to the merits, Temple and the Hospitals, as we have discussed, had prevailed on the merits of their claim that DPW had not complied with applicable federal laws and regulations and had established payment rates through methods that did not meet federal standards. As to the inadequacy of legal remedies, the Eleventh Amendment bar to an award of

retroactive damages against the Commonwealth, *see Temple*, 732 F. Supp. at 1327-28, clearly establishes that any legal remedy is unavailable and that the only relief available is equitable in nature. *See National Resources Defense Counsel*, 906 F.2d at 938, 941; *Roe*, 919 F.2d at 867 n.8.

With respect to balancing the equities, even a cursory reading of the district court's January 24, 1990 opinion demonstrates the painstaking care that the district court took in weighing the competing claims and in balancing the interests of Temple, the Hospitals, and the medically needy on the one hand, against the interests of the Commonwealth, on the other. *See Temple*, 729 F. Supp. 1093. Thus, we are satisfied that all the criteria necessary for the injunction decreed by the district court were present.

D

The district court's injunctive remedy consisted of two parts. The first and most fundamental part was the requirement imposed by the district court that DPW promulgate a new MAP. The district court's injunctive order in this respect, directed that DPW "take all necessary steps to bring the Pennsylvania Medical Assistance Plan into compliance with federal requirements consistent with [the district court's January 24, 1990] Memorandum." 729 F. Supp. at 1101. The second part of the district court's injunction required interim payments to be made by DPW to Temple and the Hospitals (to the extent that the Temple February 21, 1990 order pertains to the Hospitals), *see supra* note 14, until the new MAP takes effect. While DPW contends that its present MAP should not have been invalidated, i.e., that DPW should

have prevailed on the merits, it also attacks the interim relief which the district court provided in its orders of February 21, 1990 and March 1, 1990.

We are satisfied that the district court had inherent discretion to fashion a remedy in aid of, and in implementation of, its own judgment which required DPW to formulate a new MAP. Having determined that a new MAP was required which would provide payment rates to Temple and to the Hospitals in accordance with federal prescriptions, it is evident to us, as it must have been to the district court that, until such time as DPW complied with the January 24, 1990 order and presented a new MAP, provisional payments had to continue so that the medically needy could be served and Temple and the Hospitals could remain effective as providers of medical services. The district court's task, in a situation where a violation of this nature is found, is to correct the condition by balancing the individual and collective interests. *See Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971) (in a constitutional context). While the scope of a district court's equitable powers to effect a remedy is broad, the relief which a district court may grant can be no broader than that necessary to correct the violation. Indeed, a federal court is required to tailor the scope of its remedy in order to fit the nature of the violation which it has found. *Resident Advisory Board v. Rizzo*, 564 F.2d 126 (3d Cir. 1977), *cert. denied*, 435 U.S. 908 (1978). As we said in *Resident Advisory Board*, albeit in a constitutional context, the federal equitable remedy must cure the constitutional defect, but the dosage must not exceed that necessary to effect the cure. 564 F.2d at 145.

In this case, the district court, recognizing that any acceptable Medicaid plan must be devised by DPW, nevertheless undertook to establish an interim payment level "based upon eliminating only the most obvious and clearcut inadequacies of the present plan." 732 F. Supp. at 1328. It is clear to us that the entire focus of the district court's endeavors, once it had concluded that Pennsylvania's 1988-1989 payment rates were invalid, was to require a new payment rate plan to be formulated by DPW as expeditiously as possible and to protect that judgment by providing for interim payments which would sustain the system until such time as the new MAP was drawn and approved. Having concluded that all the criteria necessary for the injunctive relief ordered by the district court were present, both with respect to the injunctive decree requiring revision of the MAP and with respect to the injunctive decrees providing for interim relief, (particularly because it was evident that some payments had to be ordered to maintain the hospital system and to service the medically needy), we can find no fault with the action taken by the district court or with the orders entered by the district court to effectuate the objectives inherent in the Medicaid Program.

V

A

On August 14, 1990, the district court, among other things, ordered that DPW make four payments of $500,000 each to Sacred Heart Hospital as an advance against future medical assistance payments. A threshold issue of appellate jurisdiction is presented by this appeal.

We are bound to determine our own jurisdiction, even if the parties do not raise this issue. *See Firestone v. Risjord*, 449 U.S. 368, 379 (1981). In this case, the parties did not call our attention to the jurisdictional problem, and indeed, when that issue was raised, both DPW and Sacred Heart argued that we should not dismiss the appeal for failure of jurisdiction.

The district court's August 14, 1990 order was made orally from the bench and was not reduced to writing, nor was it entered on the clerk's docket. At that stage, therefore, we could not obtain appellate jurisdiction to review an unrecorded order. *Banker's Trust v. Mallis*, 435 U.S. 381 (1978), relied upon by the parties, is not to the contrary. In *Banker's Trust*, the Court recognized that no order had been written which satisfied the separate document requirement of Fed. R. Civ. P. 58. The Court also recognized, however, that the parties could waive that requirement, and, in so doing, affirmed its appellate jurisdiction over the case. However, the Court took pains to note that there had been an entry of the order in the district court clerk's docket. The Court stated:

> Here, the district court clearly evidenced its intent that the opinion and order from which an appeal was taken would represent the final decision in the case. *A judgment of dismissal was recorded in the clerk's docket.*

435 U.S. at 387 (emphasis added). Here, to the contrary, no entry of the August 14, 1990 order appears in the clerk's docket. In the absence of both a written order satisfying the "separate document" requirement and in the absence of an entry in the clerk's docket, the notice of appeal,

which was filed on September 4, 1990, could not vest jurisdiction in this court despite the parties' apparent waiver of the separate document requirement.[22]

However, an event that occurred subsequent to the August 14 order suffices to satisfy us that we have the right to review DPW's appeal. On August 23, 1990, the district court, in response to a motion filed by Sacred Heart, directed that the order of August 14, 1990, which had been sealed and which is the order under appeal here, be unsealed. Prior to that time, Sacred Heart had succeeded in having its motions to seal the pleadings and record granted. For reasons which do not appear of record, Sacred Heart moved to amend the district court's order dated August 14, 1990 by having the August 14th order unsealed. The order of the district court reads as follows:

> AND NOW, this 23rd day of August 1990, upon consideration of Plaintiff, Sacred Heart Medical Center's Motion to Amend this Court's Order dated August 14, 1990 sealing the pleadings and record herein, it is hereby ORDERED AND DECREED that:

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22. In *Banker's Trust*, the Supreme Court explained the purposes of entering a decision on the docket:

> Because Rule 58 provides that a "judgment is effective only . . . when entered as provided in Rule 79(a)," it is arguable that a decision must be entered on the civil docket before it may constitute a "final decision" for purposes of § 1291. Unlike the separate-document requirement, . . . the keeping of a civil docket pursuant to Rule 79 fulfills a public recordkeeping function over and above the giving of notice to the losing party that a final decision has been entered against it.

435 U.S. at 384 n.4.

> Said Order is amended to permit the unsealing of the Order entered by this Court at the end of the Hearing August 14, 1990. A copy of that Order is attached hereto as Exhibit A.

(SH App. 158).

It is significant to us that a copy of the August 14, 1990 order which the court ordered to be "unsealed" was attached to the unsealing order of August 23, 1990 as Exhibit A. The August 23 order *is* entered on the clerk's docket, and although the August 14 order, to which the unsealing order refers, does not appear either on the clerk's docket or in written form in the record, for purposes of appellate jurisdiction we are satisfied that the entry on the clerk's docket of the August 23 order, with its Exhibit, is sufficient to permit us to review DPW's appeal. We turn, then, to DPW's argument on the merits.

B

DPW argues first that because the district court erred in invalidating DPW's MAP and in finding that DPW was in violation of Title XIX, as it did in its *Temple* holding, that Sacred Heart's claim, which is premised on that holding, must also fail. The short answer to this argument is found in our earlier analysis of the district court's *Temple* holding, which was predicated on a failure of DPW to make its findings required by 42 U.S.C.A. § 1396 *et seq.*, and our discussion of collateral estoppel which extended the district court's *Temple* holding to the Hospitals. *See supra* §§ III and IV. We are satisfied that the decision of the district court as to liability must be sustained, and, in sustaining the orders of the district court in this respect, we reject DPW's first argument.

DPW also argues that the district court's decision to grant interim relief for Sacred Heart is against the weight of the evidence, inasmuch as Sacred Heart had a history of financial problems which DPW claims was responsible for Sacred Heart's financial plight, rather than the inadequacy of DPW's MAP. In addition, DPW argues that the district court erred when it directed that DPW make advance payments to Sacred Heart without requiring that a bond be posted pursuant to Fed. R. Civ. P. 65(c). We also briefly address the issue of mootness which was the subject of our inquiry after learning of the Settlement agreements executed by the parties. *See infra* note 5. We turn to these arguments.

(1)

On August 14, 1990, the district court judge enjoined DPW to pay $2 million in advance payments to Sacred Heart Hospital by directing:

> I, therefore, will direct that the defendants pay to the Sacred Heart Hospital beginning within 10 days from today the following sums:
>
> The sum of $500,000.00, the first payment to be made within 10 days from today and a like payment of $500,000.00 each of the next three months for a total of four months of payments or a total of $2 million spread out over the four-month period with the understanding:
>
> No. 1, that this is an advance against future medical assistance payments and the reimbursement of this $2 million in the form of credits against future medical assistance payments will begin January 18th, 1991 or 30 days after submission of an acceptable MAP plan; and

> It is further understood that upon presentation of a revised MAP plan, whenever that occurs, the defendants will be at liberty to seek a modification of this order with respect to any advances which have not yet occurred if they can establish that under the appropriate MAP plan the adjustments will not – that these additional payments will not be justified.

(SH App. 155).

The district court ordered this relief in light of underpayment of Medicaid rates to Sacred Heart in past years; DPW's failure to promulgate a new MAP providing for a higher payment rate; and the need "to make some appropriate adjustment for the interim period . . . which will prevent the insolvence [sic] or a bankruptcy of Sacred Heart Medical Center at least in that interim period. . . ." (SH App. 154).

As we have noted in an earlier part of this opinion, *see supra* note 5, sometime subsequent to the filing of the appeals that we consider today, DPW entered into a Stipulation of Settlement with Temple and the Hospitals and into a special agreement with Sacred Heart. The parties to these agreements were satisfied that entering into them did not moot out these appeals or proceedings underlying the appeals, *see, e.g.*, Stipulation of Settlement, p. 33, paragraph 6.5, and indeed, after supplementing the record on these appeals with the settlement documents, and after additional briefing, we, too, were satisfied that the appeals in gross have not been mooted.

Our determination that the appeals were still viable did not reflect the fact, however, that some aspects of the appeals may have been mooted by the action of the parties. In our view, DPW's

payments totalling $2 million, payments which had been completed, may very well have mooted DPW's argument that the district court erred in directing those payments, particularly because we understand that the agreement which DPW made with Sacred Heart would now govern the relationship of the parties with respect to those payments.

(II)

However, we do not rest our decision on the ground of mootness, for we are satisfied that the standard by which a district court's decree of injunction is tested – whether the district court properly exercised its discretion – was not abused in this case. First, as we have observed, Sacred Heart has succeeded on the merits of its claim. Second, whether or not irreparable harm is deemed a factor in the injunction analysis, as DPW claims that it is, irreparable harm has been more than demonstrated by the finding made by the district court that without emergency relief, Sacred Heart would become insolvent. (SH App. 154).

The district court further noted that even DPW did "not dispute the fact that, if a stay [of the emergency relief award] is granted, financial collapse of the Sacred Heart Medical Center is virtually certain to occur." (SH Supp. App. 5). While DPW did not dispute the fact that Sacred Heart was in severe financial straits, it did dispute the district court's finding that Sacred Heart's potential financial collapse/insolvency was related to DPW's MAP. The district court, however, found otherwise, and we cannot hold that finding to be clearly erroneous in light of the district court's determination that Sacred Heart's financial "inefficiencies" are insignificant. (SH App. 155).

A fair reading of the district court's October 18, 1990 memorandum reveals that the district court weighed the risks to DPW,[23] and balanced the interests of Sacred Heart, DPW, and the public in requiring the advance payments to be made to Sacred Heart. From any standpoint, and particularly considering the fact that no legal remedy was either adequate or available, we conclude that the district court's injunctive order was well within its broad discretionary power. Hence, even if by completing payments of the $2 million advance and the execution of the settlement agreements, the issues presented by the DPW were not moot, the injunction itself, as entered by the district court, was not an abuse of discretion.

(iii)

DPW argues that the district court erred in awarding emergency relief to Sacred Heart without requiring it to post a bond pursuant to Fed. R. Civ. P. 65(c).[24] While Rule 65(c) does state that a plaintiff shall post a security bond before a district court may grant a preliminary injunction, we have

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23. "The risk that the defendants will suffer any significant prejudice as a result of these interim payments is, for the reasons mentioned above, very slight or non-existent." (SH Supp. App. 6).

24. Fed. R. Civ. P. 65(c) provides in relevant part as follows:

> (c) Security. No restraining order or preliminary injunction shall issue except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained.

acknowledged, on several occasions, that there may be instances in which a strict reading of Rule 65(c) would be inappropriate.[25] While we have not previously addressed a situation where the bond requirement of Rule 65(c) could properly have been waived, we note that several other circuits have held that a district court may dispense with that requirement under certain narrowly drawn circumstances.[26]

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25. *See Hoxworth v. Blinder, Robinson & Co. Inc.*, 903 F.2d 186, 211 n.32 (3d Cir. 1990) (noting that if an exception to the bond requirement is drawn, it "should be drawn narrowly"); *Instant Air Freight v. C.F. Air Freight*, 882 F.2d 797, 803 n.8 (3d Cir. 1989) (recognizing that "[o]ther courts of appeal have held that certain non-commercial and public interest cases may require dispensing with the bond"); *System Operations v. Scientific Games Dev. Corp.*, 555 F.2d 1131, 1146 (3d Cir. 1977) (adding that there was no need to "decide whether a court may dispense with the posting of a bond in a case where the injunction raises no risk of monetary harm to the defendant"). *Cf. Frank's GMC Truck Center v. G.M.C.*, 847 F.2d 100, 103 (3d Cir. 1988) (noting that "[w]hile there are exceptions, the instances in which a bond may not be required are so rare that the requirement is almost mandatory").

26. *See, e.g., Crowley v. Local No. 82, Furniture & Piano*, 679 F.2d 978 (1st Cir. 1982), *rev'd on other grounds*, 467 U.S. 526 (1984) (upholding denial of bond where Union members would have had financial difficulty posting it, and where defendants faced low burden from absence of security); *International Controls v. Vesco*, 490 F.2d 1334, 1356 (2d Cir. 1974), *cert. denied*, 417 U.S. 932 (1974) (noting that "the district court may dispense with security where there has been no proof of likelihood of harm to the party enjoined") (citations omitted); *Corrigan Dispatch Co. v. Casa Guzman, S.A.*, 569 F.2d 300 (5th Cir. 1978) (trial court may elect not to require security bond where entire purchase price of disputed sale was paid into registry of court); *Urbain v. Knapp Brothers Mfg.*, 217 F.2d 810 (6th Cir. 1954) (no bond required where defendant would not appear to face material damage);

In particular, the First Circuit has articulated an appropriate analysis that a district court should employ in deciding whether or not to require a bond. *Crowley v. Local No. 82, Furniture & Piano*, 679 F.2d 978 (1st Cir. 1982), *rev'd on other grounds*, 467 U.S. 526 (1984). "First, at least in noncommercial cases, the court should consider the possible loss to the enjoined party together with the hardship that a bond requirement would impose on the applicant." *Id.* at 1000. Here, Sacred Heart was on the brink of financial ruin and would have become insolvent absent the relief which the district court ordered. Furthermore, the district court found that virtually no risk existed for DPW in advancing funds to Sacred Heart, because of the probability that the hospital would be entitled to as much or more monies pursuant to DPW's new MAP. The emergency relief itself ensured Sacred Heart's financial solvency, and DPW could recoup any overpayment of funds by withholding on future payments to Sacred Heart. The equities of potential hardships to the parties, therefore, weighed in favor of waiving the bond requirement.

The First Circuit also noted the special nature of suits to enforce important federal rights or

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Wayne Chemical v. Columbus Agency Serv. Corp., 567 F.2d 692 (7th Cir. 1977) (no bond required from indigent plaintiff); *People Ex Rel. v. Van De Kamp v. Tahoe Regional Plan*, 766 F.2d 1319 (9th Cir. 1985) (holding non-profit environmental group would be denied access to judicial review if court did not properly exercise its discretion to dispense with security requirement); *Continental Oil v. Frontier Refinery*, 338 F.2d 780 (10th Cir. 1964) (no bond required where likelihood of harm to defendant is absent).

"'public interests,'" arising "out of comprehensive federal health and welfare statutes." *Crowley*, 679 F.2d at 1000. A district court should consider the impact that a bond requirement would have on enforcement of such a right, in order to prevent undue restriction of it. *Id.* In this case, Sacred Heart has sued to enforce the rights granted to it under the federal Medicaid statute, and in so doing has pursued a course of litigation clearly in the public interest, i.e., it seeks to preserve its role as a community hospital serving a disproportionate share of low income patients.[27] In light of the district court's discussion, it appears improbable that, had the district court required Sacred Heart to post a bond, the hospital would have been able to do so. Moreover, had Sacred Heart suffered a financial collapse, it would have been in no position to pursue its claim for increased Medicaid payments, or even to serve its Medicaid patients. The district court's waiver of the bond requirement under these circumstances, then, falls within the

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27. Public policy under [federal law governing state modification of Medicaid programs] mandates that parties in fact adversely affected by improper administration of programs pursuant thereto be strongly encouraged to correct such errors. . . . [T]he allocation of risk for not complying with federal law in a comprehensive program to promote national health . . . properly rests upon the defendant governmental bodies whose administration of the program is at issue.

Bass v. Richardson, 338 F. Supp. 478, 491 (S.D.N.Y. 1971) (waiving the Rule 65(c) bond requirement).

exception to Rule 65 formulated by the First Circuit - an exception which we adopt today.[28]

VI

We have sustained the district court's invalidation of Pennsylvania's MAP, providing for 1988-1989 payment rates, and the remedies ordered by the district court, including the district court's requirement that a new MAP be devised which complies with all requirements of Title XIX. We have also upheld the interim remedies fashioned by the district court which will remain in effect until DPW complies with the district court's order of January 24, 1990. With respect to Sacred Heart, we have sustained the district court's order for advance payments which were to be made without bond. Accordingly, the district court's orders of January 24, 1990 (Temple); February 21, 1990 (Temple); March 1, 1990 (Hospitals); August 14, 1990 (Sacred Heart); and August 23, 1990 (Sacred Heart) will be affirmed in all respects.

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28. Because we have upheld the district court's injunction requiring the payment of advances to Sacred Heart, even if we had not adopted an exception to Rule 65 and had, therefore, concluded that the district court had erred in not requiring a bond, DPW would only have been entitled to a remand for reconsideration of that issue. *See Crowley*, 679 F.2d at 1000. The district court could have, at that point, required the posting of a nominal bond, and the case would have proceeded apace. *See Frank's GMC*, 847 F.2d at 103 (noting that "the amount of the bond is left to the discretion of the court").

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

(A.O. U.S. Courts. G.M.C. Printing. Phila., Pa. 215-568-4264)

TEMPLE UNIVERSITY--OF THE
COMMONWEALTH SYSTEM
OF HIGHER EDUCATION

v.

John F. WHITE, Jr.; Eileen M. Schoen; David S. Feinberg; David D. Ulsh; and G. June Hoch.

Civ. A. 88-6646

United States District Court,
E.D. Pennsylvania.

Jan. 24, 1990.

Matthew M. Strickler of Ballard, Spahr, Andrews & Ingersol, Philadelphia, Pa., for plaintiff.

Kate L. Mershimer, Deputy Atty. Gen., Harrisburg, Pa., for defendants.

MEMORANDUM AND ORDER

FULLAM, Chief Judge.

Plaintiff is a Pennsylvania non-profit corporation which operates Temple University Hospital. It has brought this action against various officials of the Commonwealth of

Pennsylvania, invoking 42 U.S.C. § 1983, asserting that the defendants have deprived Temple of rights secured by Title XIX of the Social Security Act, 42 U.S.C. § 1396a et seq. in their administration of the payment system for in-patient hospital care under the Pennsylvania Medical Assistance Program.

At issue are such matters as whether defendants are meeting the statutory requirement that the State's Medical Assistance program must provide payments to hospitals that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals; whether Pennsylvania's Medical Assistance program is based upon the statutorily required findings and certification; and whether the Program adequately takes into account the special problems of hospitals which,

like Temple, serve a disproportionate number of low-income patients. Before addressing the merits, however, it is necessary to refer briefly to defendants' threshold argument that plaintiff cannot maintain this action under 42 U.S.C. 1983 for violation of alleged federal statutory rights, because Title XIX gives rise to no rights which can be asserted by hospitals. This precise argument has been persuasively rejected by the Third Circuit Court of Appeals in West Virginia Univ. Hospitals, Inc. v. Casey, et al., 885 F.2d 11 (3d Cir., 1989), and I am bound by that decision.[1]

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[1] I recognize that the United States Supreme Court has recently granted review of a Fourth Circuit decision to the same effect as West Virginia Hospital, in Virginia Hospital Ass'n v. Baliles, 868 F.2d 653 (4th Cir.1989), cert. granted, ___ U.S.____, 110 S.Ct. 49, 107 L.Ed.2d 18, (1989). In addition to these Third and Fourth Circuit decisions, I

CONTINUED ON NEXT PAGE

I. FACTUAL BACKGROUND

For several years, hospitals received reimbursement for costs actually expended in the care of Medicaid patients, on the basis of cost figures submitted to and audited by the appropriate state authorities. In the belief that this reimbursement system provided inadequate incentives to hospitals to operate efficiently, and in order to cope with rapidly escalating Medicaid hospital costs, Congress, as part of the '81 Omnibus Reconciliation Act (OBRA), P.L. 97-35, established a new standard of hospital reimbursement.

FOOTNOTE 1 CONTINUED
note that virtually every court of appeals which has squarely considered the question has found that hospitals can challenge state Medicaid plans under § 1983. The cases are listed in the most recent decision of the Tenth Circuit on this subject, Amisub (PSL), Inc. v. State of Colorado, Dept. of Social Services, 879 F.2d 789, 794 (10th Cir.1989).

Whereas, previously, hospitals were to be reimbursed "the reasonable cost" of rendering in-patient services; the OBRA replaced that standard with the current standard requiring payments to hospitals at rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities". 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp.1989). The statute and accompanying regulations afford considerable leeway to the States to determine the precise methods by which payments to hospitals will be calculated in order to meet the statutory standard, but require States to make findings and give assurances that the plan adopted does in fact comply with federal requirements.

Pennsylvania's Medical Assistance Program established a complex system for classifying hospitals into groups thought

to face similar external constraints affecting their costs; classifying medical procedures performed in hospitals into groups thought to involve essentially similar costs; calculating the average cost per procedure, experienced by hospitals in each group; and, after various adjustments including a so-called "budget neutrality factor" and an upward adjustment for hospitals burdened disproportionately with indigent patients, resulting in a formula by which hospitals are paid prospectively, without regard to their actual expenditures. The changeover from the old system to the new system was phased in over a three-year period.

The Third Circuit Court of Appeals, in West Virginia Univ. Hospitals, supra, held that this precise medical assistance plan was invalid, for non-conformity with the requirements of Title XIX, insofar as

it affected out-of-state hospitals. That holding is not, of course, directly controlling in the present case, because we are dealing with in-state hospitals, and with a different reimbursement formula. But the thorough discussion and analysis of the statute, the regulations, and the legislative history provided by Judge Rosenn's opinion in that case makes it unnecessary to undertake a similar exposition here. It is sufficient to note that Judge Rosenn identifies three criteria which medical assistance plans must meet in order to conform to Title XIX: (1) the plan must take into account the situations of those hospitals which serve a disproportionate number of low-income patients; (2) the plan must be based upon a finding and certification that the rates are reasonable and adequate to meet the necessary costs of

an efficiently operated hospital; and (3) the plan be based upon a finding and certificate that the rates will assure Medicaid patients reasonable access to in-patient hospital care. Judge Rosenn refers to these as the "disproportionate share; requirement, the "reasonable and adequate" requirement, and the "reasonable access" requirement. As to the first and third, judicial review is plenary, but as to the "reasonable and adequate" standard, judicial review is limited to inquiring whether the state's determination is arbitrary and capricious (slip op. pp. 24, 25). Notwithstanding this deference to the state's determination of what constitutes a

reasonable and adequate rate of reimbursement, the process by which that determination was reached--the adequacy of its factual investigation and findings-must also conform to the statutory requirements.

Temple's Experience

Temple University Hospital serves a North Philadelphia community which is principally black, hispanic and indigent. The majority of Temple's patients are blacks and hispanics who live in poverty. Fifty-percent of Temple's patients have Medicaid insurance coverage; 20% are covered by Medicare; and 5% have no coverage.

Approximately 2,100 children are born at Temple Hospital each year. The neo-natal mortality rate in that community is more than twice the national average. Approximately 20% of the

mothers enter Temple Hospital without having had any prenatal care. Many are addicted to drugs; about 20% of the babies born at Temple Hospital show evidence that their mothers consumed cocaine during pregnancy. Six percent of the babies born at Temple suffer from low birth weight or other problems, including sexually transmitted diseases.

Nursing costs represent approximately 22% of Temple's total operating costs. Although Temple does not have the highest pay scale in the area, the rate of pay for nurses at Temple increased more than 37% between 1980 and 1988. Because of its pay scale, Temple has difficulty retaining nurses; its ratio of nurses to occupied beds is among the lowest of the teaching hospitals. Temple's professional liability insurance costs and similar

obligations beyond its control have increased dramatically in recent years. For example, its premium for Pennsylvania's Catastrophic Loss Fund increased approximately 400%. Utility costs have increased at a rate of approximately 20% to 12% per year; the cost of disposable supplies and pharmaceuticals has increased at the rate of approximately 9.5% each of the last several years.

On average, Philadelphia medical school hospitals employ 6.1 full-time employees per occupied bed; Temple's rate is 5.3. Temple's housekeepers are required to clean between 30% and 50% more square footage than the industry norm.

Temple's current occupancy rate is approximately 84% to 85%, an increase of 21% since 1984.

Under the Department of Public Welfare's ranking system, Temple is one of seven hospitals with the highest score; it has the least costs of these seven hospitals; its costs are below the weighted average cost of all hospitals classified in the same group under the Medical Assistance Program (Class 1).

Under the Pennsylvania Medical Assistance Program, Temple receives approximately 81% of its actual costs for medical assistance patients; during fiscal year 1988-89, Temple will lose approximately $7.8 million on in-patient care to medical assistance patients.

During each of the years since the inception of the prospective payment system, Temple's medical assistance payments have been inadequate to cover its medical assistance reimbursable costs. The shortfall between its costs

for medical assistance in-patient care and its reimbursement have been as follows:

FY '1985 - $2,504,617

FY '1986 - $2,525,899

FY '1987 - $5,086,863

FY '1988 - $6,218,785

FY '1989 - (estimated) $7,790,427

To some extent, Temple has been able to achieve cross- subsidization from other payors, but it will nevertheless experience a loss of $3,256,155 on in-patient care during the current fiscal year. Its loss for fiscal year 1989-90 is expected to rise to somewhere between $4.5 and $5.2 million on in-patient care.

Plaintiff presented a mass of evidence, which stands unrebutted, to the effect that it has cut costs in every conceivable way, and that, as a practical matter, no further "efficiency" or "economy" is possible.

Defendants' response, in essence, is that since the Medical Assistance Plan is designed to provide reasonable and adequate reimbursement of the costs which would necessarily be incurred by an efficient institution, the shortfall between Temple's costs and the reimbursement provided by the Plan is proof that Temple is not an efficient hospital. Although this seems, at first blush, to be a rabbit-in-the-hat type of argument, it is one which follows inevitably from the design of the Medical Assistance Plan established by the defendants, as will be discussed in the following section.

II. REASONABLE AND ADEQUATE COSTS INCURRED BY EFFICIENT AND ECONOMICAL HOSPITALS

[1] Opponents and proponents of the Pennsylvania Medical Assistance Plan

(MAP) agree on certain basic principles. What in-patient care should reasonably cost depends upon the nature of the care provided, and the circumstances of the provider. The first step in the analysis, therefore, is to identify and classify the diseases or conditions which require in-patient hospital care. Thus, Pennsylvania's MAP identifies some 477 categories of Diagnostic-Related Groups (DRGs). For each DRG, a flat fee is established, regardless of whether the patient actually received more or less than the standard treatment. In Pennsylvania, the relative value for each DRG is computed by:

(a) determining the total standardized cost for all approved claims in the data base (i.e., previous experience);

(b) determining the total number of medical assistance hospital cases in the data base;

(c) dividing the total standardized cost by the total number of cases to establish a statewide average cost per case for all cases;

(d) determining the total standardized costs and total number of cases for each DRG;

(e) dividing the total costs for each DRG by the corresponding number of cases for that DRG to establish an average cost per case for each DRG; and

(f) dividing the average cost per case for each DRG by the statewide average cost per case for all cases to establish the relative value for each DRG [Stipulation 38].

Thus, historical costs for similar kinds of hospital admissions are the starting point for calculating reimbursements under the plan.

The next step under the Plan was to classify hospitals into groups, in an effort to treat similarly situated institutions in similar fashion. The classification process involved ranking each institution on a series of 13 variables in 4 categories, teaching, medical assistance volume, environment and cost. The variables included such matters as number of full-time employed physicians/residents/interns per bed; number of full-time equivalent physicians, residents and interns; and number of residency programs (the teaching concept variables); medical assistance reimbursable in-patient costs, separately and in relation to total

in-patient costs; acute care in-patient medical assistance in-patient days, separately and in relation to total acute care in-patient days (medical assistance volume concept); percentage of persons below the poverty level in that county, median family income in that county, percentage of unemployment in that county (environmental characteristics); and medicare area wage index, total in-patient expenses adjusted for direct medical education and capital/total in-patient admissions; and total in-patient expenses adjusted for direct medical education and capital/total in-patient days (hospital costs concept). [Stipulation 41.] For each of these 13 variables, a hospital would recieve a numerical score which resulted in a separate ranking within each concept area.

On the basis of these numerical rankings, hospitals were placed in any one of eight groups. Three children's hospitals were placed in a separate group, and the remaining hospitals divided into seven groups. Group 1 hospitals have the highest cost-factors, group 7 the lowest. A separate group payment rate was established for each group.

The defendants pegged the group rate for each group at somewhat more than the costs incurred by the lowest-cost hospital within that group, but considerbly less than the costs incurred by the average hospital within that group. Presumably, this was done on the theory that similarly situated hospitals should be encouraged to emulate the example of the lower-cost hospitals within that group.

The defendants pegged the group rate for each group at somewhat more than the costs incurred by the lowest-cost hospital within that group, but considerably less than the costs incurred by the average hospital within that group. Presumably, this was done on the theory that similarly situated hospitals should be encouraged to emulate the example of the lower-cost hospitals within that group.

There are several problems with this approach, both theoretical and practical. Assuming that the hospitals are grouped appropriately, and that the hospitals within a particular group are indeed similarly situated, and assuming that the lowest-cost hospitals within that group are the most efficient, the incentive is double-edged: whereas some fairly low-cost institutions might be encouraged to reduce their costs still

further, those at the higher end of the spectrum within a particular group would do better to increase their costs and become less "efficient", in order to qualify for membership in the next-higher group. In short, grouping hospitals according to their actual cost experience (rather than in accordance with the similarity of their circumstances affecting costs), produces a result having little or nothing to do with whether the hospitals are being run efficiently and economically.

This difficulty is exacerbated by the fact that hospitals are assigned to groups, not because their scores on the ranking test were comparable, but simply in order to achieve seven groups of near-equal size. Thus, there is greater variation among the hospitals in group 1 (the scores in that group range from 913 to 724) than there is between the

highest-scoring hospital in group 3 (608) and the lowest- scoring hospital in group 7 (439).

Group 1 hospitals rank highest in teaching, medical assistance volume, environmental factors, and costs. But the hospitals assigned to that group are far from homogeneous. The group includes the six Philadelphia teaching hospitals (Temple, Penn, Jefferson, Medical College of Pennsylvania, Hahnemann, and Osteopathic); Germantown Hospital, a primary- care hospital in Philadelphia; and Springfield Hospital in Delaware County. Within that group, the ratio of full-time residents per bed varies from .688 (Medical College of Pennsylvania) to .124 (Springfield); the ratio of acute-care medical assistance costs to total costs varies from .361 (Temple) to .042 (Springfield).

In order to receive full medical assistance reimbursement, a hospital must rank relatively low within its group. It is simply impossible for a hospital such as Temple, which ranks high in the group, to receive payments equal to its costs. Plaintiff's statistical expert, Dr. Siskin, has convincingly demonstrated that whether a hospital will or will not receive full-cost reimbursement is, under the MAP, essentially unrelated to efficiency; it depends upon where it ranks, within that particular group, on the variables; the higher ranking within the group, the greater the likelihood, even certainty, of a shortfall. But the very purpose of rank- scoring on the variables was to identify the hospitals entitled to higher rates of reimbursement.

A further, major, difficulty with Pennsylvania's MAP is that, after

determining the group rate for each group, application of a "budget neutrality" factor results in an across-the-board 14% reduction. That is, hospitals within each group receive only about 86% of the costs incurred by the hospitals at the lower end in that group.

The defendants' attempts to justify this reduction are not entirely consistent with each other, or with the evidence. Initially, the concept of a budget-neutrality adjustment was introduced as a part of the transition to the system of prospective payment; it was designed to make sure that total payments under the prospective payment system would not exceed what they would have been for the same level of services, under the old system. Another justification advanced by the defendants is that, under the old system, there was

usually a shrinkage between the cost figures submitted by hospitals in claiming reimbursement and the final audited figures. Since the prospective payment formula was based in part upon the hospitals' (unaudited) costs, it was reasonable to suppose that there should be a similar shrinkage between the defendants' initial projections and the correct prospective payment estimate.

These theoretical justification do not hold water. The discrepancy between audited and unaudited cost figures under the old system seldom, if ever, exceeded 2%; and no attempt has been made to determine, in recent years, how the total cost under the new system compares with the costs which would have been incurred had the old system remained in effect. The defendants' own calculations at the time projected little or no difference.

Plaintiff's expert, Dr. Coelen, performed a study suggesting that the maximum budget neutrality adjustment should be only about 2.4%.

The evidence makes very clear that the "budget neutrality" adjustment, like other features of the MAP, is entirely budget-driven. It is simply a mechanism for keeping total medical assistance costs within the Welfare Department budget. Moreover, the across-the-board approach--applying the adjustment equally to all hospitals and all groups without regard to their relative level of efficiency or other pertinent circumstances--is utterly inconsistent with the notion of rewarding efficiency.

In short, Pennsylvania's reimbursement rates are simply arbitrary.

III.DISPROPORTIONATE SHARE ISSUES

[2] In order to comply with Title XIX, the MAP must use rates established according to standards "which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs ...". There is no dispute about the fact that Temple does serve a disproportionate number of such indigent patients. Pennsylvania's MAP provides for additional payments to such hospitals, ranging from a low of 0.5% to a high of 2.5%. Temple qualifies for the 2.5% add-on. Unfortunately, it is also undisputed that this represents only a small fraction of the total increase in costs attributable to Temple's status as a disproportionate-share hospital. As the defendants' own calculations demonstrate, full

recognition of Temple's status as a disproportionate-share hospital would result in an add-on of at least 16%. The parties disagree as to whether this is in conformity with Title XIX.

The statute permits states to calculate the required additional payments to disporportionate-share hospitals either by adopting the same formula used in the Medicare Program, or by adopting their own formulas. It is clear that Pennsylvania rejected the Medicare formula because it would be too expensive. The defendants then worked out a formula which would have produced add-ons in the range of 4% to 5%. This was never implemented, however, because of budgetary considerations. In the final analysis, the defendants simply allocated to disproportionate-share hospitals the funds available; this

turned out to produce the maximum reimbursement of 2.5%.

The statute does not mandate any particular level of payments for disproportionate-share hospitals. It does, however, require payments which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws"; and it requires that such rates are to be determined in accordance with standards which "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs".

Whether the Pennsylvania plan can properly be said to have taken the situation of disproportionate-share hospitals into account when it falls so

far short of meeting the medical assistance costs associated with disporportionate-share activities is a close question. By specifying either the Medicare system or an alternative system devised by the States, Congress seems to have contemplated that the State's plan would produce comparable results. The 2.5% override provided by the Pennsylvania Plan is only about 1/10 of the amount which would be payable under the Medicare analysis (2.5% versus 20.93%).

Recognizing that States are given a considerable amount of flexibility in this area, and that reimbursement rates are to be fixed by the State, not by this court, I am nevertheless constrained to hold that Pennsylvania's adjustment for plaintiff's disproportionate-share status misses the mark by so wide a margin as to

be inconsistent with the intent of Congress.

IV. PROCEDURAL ISSUES

[3] Finally, it seems clear that Pennsylvania's Medical Assistance Plan was adopted without compliance with the procedural requirements of Title XIX and the applicable regulations. Section 447.253(b) of the applicable regulations provides:

> "(b) Findings--Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> "(1) Payment Rates--
>
> "(i) the Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate

to meet the cost that must be incurred by efficiently and economically operative providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

"(ii) With respect to in-patient hospital services--

"(A) the methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs ..."

42 C.F.R. § 4471253(b) (1988).

So far as the record discloses, Pennsylvania did not make findings based upon empirical studies--on such matters, for example, as the characteristics of an

efficient and economical hospital operation, the impact of the proposed reimbursement rates upon hospitals' ability to survive, etc.--but merely certified that its plan complied with the statutory requirements. But, as stated by the Tenth Circuit Court of Appeals,

> "Mere recitation of the wording of the federal statute is not sufficient for procedural compliance. There is a presumption that the State will engage in a bona fide finding process before it makes assurances to HCFA that the required findings have been made. To rule otherwise would completely eviscerate the federal requirements so long as the magic words are submitted to HCFA. Amisub, supra, 879 F.2d at 797.

Indeed, our own Court of Appeals has expressly held that Pennsylvania's plan is procedurally defective, at least with respect to out-of-state hospitals. The court pointed out:

> "In structuring its out-of-state reimbursement program, Pennsylvania admits to gathering no information with respect to these hospitals' actual costs. No empirical analysis was conducted to measure the effects of the reimbursement program on out-of-state hospitals.... Federal law is not satisfied if a State merely makes conceptual policy decisions. A policy predicated upon provincialism and self-interest, not upon findings of reasonableness and adequacy, is unacceptable. We hold that the federal regulations unambiguously require the State to

make findings In failing to make these requisite findings, Pennsylvania violated federal law." West Virginia Hospitals, supra at 30.

I therefore conclude that the Pennsylvania plan was adopted without adequate compliance with the procedural requirements of the statute.

V.SUMMARY OF LEGAL CONCLUSIONS

For the reasons set forth above, I have concluded that the Pennsylvania Medical Assistance Plan was adopted without compliance with the procedural requirements of Title XIX and the implementing regulations because of the absence of meaningful findings based upon reasonable investigation. I have further concluded that, as applied to the plaintiff, the Pennsylvania Medical Assistance plan violates the statute, 42 U.S.C.A. § 1396a (a) (13) (A) (West

Supp.1989) both because it fails to provide payments at rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and because the rates do not adequately "take into account the situation of hospitals [including plaintiff] which serve a disproportionate number of low-income patients with special needs;" the rates are properly characterized as arbitrary.

I accept defendants' argument that plaintiff has made no showing, on this record, that Medicaid patients are being denied reasonable access to in-patient hospital care. But the fact that such denial of access has not yet occurred provides no assurance of reasonable access in the foreseeable future. Indeed, the evidence presented justifies

the conclusion that, absent prompt corrective measures, denial of reasonable access to inpatient hospital care for Medicaid patients is almost inevitable.

VI. REMEDY

It is clear that the plaintiff is entitled to a declaratory judgment, and to an injunction requiring the defendants to bring the Pennsylvania Medical Assistance Plan into conformity with federal requirements. That much relief will therefore be ordered at this time. What is less clear, however, is the extent to which retroactive relief can be ordered, given the limitations of the Eleventh Amendment and Edelman v. Jordan, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974).

As explained in Bennett v. White, 865 F.2d 1395, 1408 (3d Cir. 1989),

> "It is one thing for a state to insist that the Eleventh Amendment prevents retroactive relief which affects its fisc. It is quite another to insist that the State can confer an unwanted bonanza upon the United States by refusing to make an accounting and recover available funds from the federal treasury."

The Eleventh Amendment does not, presumably, preclude prospective relief which directly affects the state treasury-- e.g., an injunction requiring that, pending modification of the Medical Assistance Plan, the defendants make payments to plaintiff at a higher level, so as to preclude further damage from the statutory violations. It would also be appropriate, under Bennett v. White, supra, to require the defendants to take appropriate actions to recapture, so far

as possible, additional sums from the federal treasury retroactively. But I believe it preferable to obtain additional clarification on these points before framing a final order addressing those issues.

ORDER

AND NOW, this 24th day of January, 1990, upon consideration of the arguments and evidence presented, it is hereby ADJUDGED that the Pennsylvania Medical Assistance Plan:

1. was adopted without compliance with the procedural requirements of the applicable federal laws and regulations;

2. applies payment rates which are arbitrary, and inadequate to meet the costs which must be incurred by efficiently and economically operated hospitals; and

3. applies rates which fail to adequately take into account the circumstances of hospitals which serve a disproportionate number of low-income patients with special needs.

IT IS THEREFORE ORDERED that the defendants shall promptly take all necessary steps to bring the Pennsylvania Medical Assistance Plan into compliance with federal requirements consistent with the accompanying Memorandum.

FINALLY, the parties are directed to clarify within ten (10) days their respective positions concerning the appropriate level of intermim payments pending modification of the Plan, and possible retroactive recovery of additional federal or other funds, consistent with Eleventh Amendment restrictions.

TEMPLE UNIVERSITY OF THE
COMMONWEALTH SYSTEM OF
HIGHER EDUCATION

v.

JOHN F. WHITE, JR., et al.,
Civ. A. No. 88-6646

United States District Court
E.D. Pennsylvania

Feb. 21, 1990.

Matthew M. Strickler of Ballard, Spahr, Andrews & Ingersoll, Philadelphia, Pa., for plaintiff.

Kate L. Mershimer, Deputy Atty. Gen., Harrisburg, Pa., for defendants.

MEMORANDUM AND ORDER

FULLAM, Chief Judge

By Memorandum and Order dated January 24, 1990, 729 F.Supp. 1093, I ruled that Pennsylvania's plan for funding Medicaid costs did not comply with the requirements of the federal statute, and would have to be revised. I left open for further proceedings the question of what, if any, interim relief

should be provided plaintiff Temple University, pending final adoption of a satisfactory plan by the defendants. These questions have now been addressed in further briefing, and at a hearing held February 20, 1990.

[1] I have concluded that Eleventh Amendment considerations preclude mandating additional payments on a retroactive basis-i.e., recalculating payments made to plaintiff before January 24, 1990. The Federal Government is responsible for 56% of these costs, but the Commonwealth treasury is the source of payment of 44% of these costs. Thus, unlike the situation in Bennett v. White, 865 F.2d 1395 (3d Cir.), cert. denied, ___ U.S. ____, 109 S.Ct. 3247, 106 L.Ed.2d 593 (1989), upon which plaintiff relies, to require the defendants to seek

increased retroactive allocations of federal funds (which should and would have been provided if Pennsylvania's plan fully complied with the federal statute) would inevitably require direct payments (to the extent of 44%) from the state treasury-a result precluded by Eleventh Amendment jurisprudence.

[2] This should not mean, however, that the defendants can await the eventual adoption of a revised plan without taking any steps to avoid further unnecessary damage to plaintiff from continued implementation of the defective plan at the funding levels which have been determined not to satisfy federal requirements. Although the task of framing an acceptable Medicaid plan must be left to the defendants, once this court's jurisdiction has been invoked, it

is appropriate to grant interim relief to mitigate irreparable loss which the plaintiff would otherwise suffer, pending final action on a revised plan.

Under the present plan, plaintiff's current payment rate is $2695.51. Plaintiff earnestly contends that full compliance with the requirements of the federal statute (i.e. full payment of costs experienced by efficient hospitals), would require that the rate be increased to $4380.32. The defendants suggest that, at most, the $2695.51 figure should be increased by 11.6% (by eliminating part of the "budget neutrality" reduction which produced the current rate); this would produce a payment rate of $3,008.19.

While it is entirely possible that, when the Pennsylvania plan has been

revised in order to bring it into full compliance with the federal statute, Temple's calculations may prove to be substantially correct, I am not prepared to make any such assumptions at this early stage. It is preferable, I believe, to establish an interim payment level based upon eliminating only the most obvious and clearcut inadequacies of the present plan.

One of the principal defects in the present plan is the lack of homogeneity among hospitals assigned to Class 1. If the lowest-cost, most dissimilar, institutions are eliminated from that group for purposes of calculating the rate, the remaining seven hospitals seem reasonabiy homogeneous in all significant respects. If only those seven hospitals are included, the basic rate would be

$3,084.23 (rather than the $2,805.85 figure which serves as the starting point under the present plan). Adjusted for inflation since 1987, using only the defendants' adjustments, the base rate becomes $3,265.66. I recognize that Temple makes a persuasive argument that the defendants' inflationary adjustments are incorrect; but I believe such refinements are best left to the final revisions the plan, and that some allowance should be made for the (faint, in my view) possibility that the new grouping unduly favors plaintiff.

A second major problem with the existing plan is its use of the arbitrary budget neutrality reduction of 14%. While it is probable that this factor should be eliminated altogether, it is conceivable that as much as 2.4% could be justified (based upon assumed differences between projections and actual costs).

Applying a 2.4% budget neutrality factor, the base rate becomes $3,187.28. With the agreed "capital add-on", the figure becomes $3,311.90.

The final question is what adjustment should be made for the fact that plaintiff serves a disproportionate share of indigent patients. The statute permits the defendants either to adopt the Medicare formula for that adjustment, or to devise their own appropriate adjustment. If the Medicare formula were applied, the disproportionate share add-on would be 21.37%. The existing plan uses, instead, a 2.5% figure. I remain convinced, as set forth in my earlier Memorandum, that Congress intended disproportionate share institutions to receive an adjustment in the same ball park as the Medicare calculation would produce, but without

limiting the states to that precise formula. Regardless of the correctness of that view, when the state, without explanation or justification, provides a disproportionate share add-on of only 2.5%, it cannot be said to have made due allowance for the situation of a disproportionate share institution.

The plaintiff argues that, since the State has not provided an acceptable alternative calculation of the disproportionate share add-on, the court should enforce the other alternative sanctioned by Congress, namely, the disproportionate share add-on which the Medicare formula would produce. I do not believe, however, that this would represent the best interim solution; the defendants, too, must deal with budgetary shortfalls.

Although the 21.37% suggested by Medicare will not be mandated, it does

seem to me that, even on an interim basis, the disproportionate share add-on should be not less than 10%. Stated otherwise, it is utterly unrealistic to suppose that the actual incremental costs associated with Temple's disproportionate share status are much less than one-half of what Medicare would estimate them to be.

Applying the 10% disproportionate share add-on produces a final payment rate of $3,643.09. The defendants will be ordered to apply that rate with respect to all bills paid or to be paid on or after January 25, 1990, pending defendants' submission of their revised plan.

[3] The defendants have requested that, in the event interim relief is ordered, plaintiff be required to post

security, guaranteeing repayment in the event the interim payments ordered by this court exceeds the amounts ultimately determined to be appropriate. Given the ongoing relationship between plaintiff and the defendants, however, it is reasonable to suppose that the defendants would be able to recapture any such excessive payments, by additional reductions in future payments, in the unlikely event that becomes necessary. I believe it is inappropriate to make a bad situation worse for both sides by imposing upon plaintiff the additional expense associated with obtaining a surety bond which, as a practical matter, would be of little real benefit to the defendants.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

TEMPLE UNIVERSITY-OF COMMONWEALTH SYSTEM OF HIGHER EDUCATION.....	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., et al.,	:	NO. 88-9848

ORDER

AND NOW, this 21st day of February, 1990, it is ORDERED:

That, pending final revision of its Medicaid plan in conformity with this court's Memorandum and Order of January 24, 1990, the defendants shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09.

IT IS FURTHER ORDERED that if it is later finally determined, either in this litigation or in the implementation of an acceptable revised medical assistance

plan, that the amounts received by plaintiff pursuant to this Order are excessive, plaintiff shall promptly refund the excess, either by payment or by credit against future entitlement.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

HOSPITAL ASSOCIATION OF PENNSYLVANIA, et al.	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare,	:	NO. 88-9848

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

ALBERT EINSTEIN MEDICAL CENTER, et al.,	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare,	:	NO. 88-8831

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES D!STRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

HAHNEMANN UNIVERSITY HOSPITAL, et al.,	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare, et al.,	:	NO. 88-9132

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

FRANKFORD HOSPITAL	:CIVIL ACTION
v.	:
JOHN F. WHITE, JR., Secretary of Public Welfare, et al.,	:NO. 88-8927

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

(2)

No. 91-732

In The

Supreme Court of the United States

October Term, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY – OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

**Petition For A Writ Of Certiorari To The
United States Court Of Appeals
For The Third Circuit**

BRIEF IN OPPOSITION OF RESPONDENTS THE HOSPITAL ASSOCIATION OF PENNSYLVANIA AND 130 HOSPITALS

ROLAND MORRIS
(Counsel of Record)
ALLEN C. WARSHAW
PAULA GAYLE SANDERS

DUANE, MORRIS & HECKSCHER
305 North Front Street
P.O. Box 1003
Harrisburg, PA 17108-1003
(717) 238-8161

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

COUNTER-STATEMENT OF THE QUESTIONS PRESENTED

I. Whether this Court should overrule its own recent decision in *Wilder v. Virginia Hospital Association*, ___ U.S. ___, 110 S. Ct. 2510 (1990) that the Boren Amendment is enforceable in an action brought by health care providers under Section 1983?

II. Whether this Court should review the lower courts' narrow ruling that petitioners violated the disproportionate share requirements of the Social Security Act with regard to one of the respondent hospitals?

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

STATUTES

TABLE OF AUTHORITIES – Continued

BRIEF FOR RESPONDENTS

The opinions below and the basis of this Court's jurisdiction are set out at pages 1 and 2 of the brief for petitioners (hereinafter Pet. Br.), and the text of the relevant federal statutes appears at Pet. Br. 3-6. This brief in opposition is filed on behalf of respondents, the Hospital Association of Pennsylvania ("HAP") and 130 hospitals, appellees in the case *Hosp. Ass'n of Pennsylvania, et al. v. White, et al.*, No. 90-1206 (3d Cir.) (Pet. App. 3a).[1]

COUNTER-STATEMENT OF THE CASE

This action began in 1988 when the Pennsylvania Department of Public Welfare (hereinafter the "Commonwealth") issued rate notices to acute care hospitals participating in the Medicaid Program.[2] The District Court subsequently determined that those rates violated both the procedural and substantive requirements of the Social Security Act, as embodied in the "Boren Amendment."[3]

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[1] A list of the respondents on whose behalf this brief in opposition is filed, along with the disclosures required by Sup. Ct. R. 29.1, is set out in the appendix to this brief.

[2] The Medicaid Program is a joint federal/state program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396(a)-1396(u).

[3] The Boren Amendment sets forth requirements states must meet when setting the rates to which hospitals, nursing and intermediate care facilities are entitled. 42 U.S.C. § 1396a(a)(13)(A). *See also, Wilder v. Virginia Hosp. Ass'n*, ___ U.S. ___, 110 S. Ct. 2510, 2513-2514, n.2 (1990).

Pet. App. 91a-92a. The Third Circuit Court of Appeals affirmed that holding. Pet. App. 27a.

Petitioners do not assert in this Court that the lower court erred in holding that the Commonwealth violated the Social Security Act by failing to make the required findings or by issuing rates which were not "reasonable or adequate." Nor indeed can they.[4] Rather, they seek to insulate their rate making process from judicial review by challenging respondents' right to institute these actions.[5]

PROCEDURAL HISTORY

This case is before the Court on a Petition for a Writ of Certiorari to the United States Court of Appeals for the

[4] For instance, petitioners introduced no evidence to support their claim that their rate setting process complied with the Boren Amendment. *See e.g.* Pet. App. 27a, n.12 ("counsel for DPW insisted repeatedly that DPW had made findings in compliance with [the Boren Amendment]. Despite persistent questioning from the court, however, counsel failed to point to a single specific finding in the record . . . Neither have we found such a finding in the documents and testimony . . . . ").

[5] They also challenge the lower courts' ruling that the Commonwealth violated the disproportionate share requirements of the Social Security Act with regard to one of the respondent hospitals. In the interest of judicial economy, and because they have not received a dispositive ruling on this issue, respondents herein do not address this issue separately. Rather, they join in the arguments asserted by their co-respondents.

Third Circuit. The case before the Court of Appeals consisted of six consolidated appeals,[6] all of which challenged the validity of the Commonwealth's payment to hospitals participating in the Medicaid Program (Pet. App. 13a), and all of which were at different procedural stages, as more fully explained below.

Temple University ("Temple") was the first hospital to file suit in the United States District Court for the Eastern District of Pennsylvania. (C.A. No. 88-06646 (E.D. Pa.)). Shortly thereafter, four additional hospital suits were filed.[7]

All of the hospitals challenged the Commonwealth's compliance with the procedural and substantive requirements of the Boren Amendment. Additionally, those hospitals designated as disproportionate share hospitals pursuant to § 1396a(a)(13)(A) and 42 U.S.C. § 1396r-4 also challenged the Commonwealth's disproportionate share payments.

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[6] The issues raised in *Hosp. Ass'n of Pennsylvania, et al. v. White, et al.*, No. 90-1661 (3d Cir.), on behalf of Sacred Heart Medical Center, are not before this Court. Therefore, the procedural history of that specific appeal will not be discussed herein.

[7] Those cases, listed in the order in which they were filed, are: *Albert Einstein Medical Center, et al. v. White, et al.*, No. 90-1203 (3d Cir.) and C.A. 88-08831 (E.D. Pa.); *Frankford Hospital v. White, et al.*, No. 90-1204 (3d Cir.) and C.A. 88-08927 (E.D. Pa.); *Hahnemann University Hospital, et al. v. White, et al.*, No. 90-1205 (3d Cir.) and C.A. 88-09132 (E.D. Pa.); and *Hosp. Ass'n of Pennsylvania, et al. v. White, et al.*, No. 90-1206 (3d Cir.) and C.A. 88-09848 (E.D. Pa.).

The District Court did not consolidate the various related actions and, instead, proceeded to trial in the *Temple* case alone. Participation by the other hospitals was limited to the filing of supportive amici briefs, although some hospitals also filed motions for summary judgment under their own captions.

On January 24, 1990, the District Court issued its Memorandum and Order, holding that the Commonwealth's Medicaid reimbursement plan:

> 1) was adopted without compliance with the procedural requirements of the applicable federal laws and regulations;
>
> 2) applies payment rates which are arbitrary, and inadequate to meet the costs which must be incurred by efficiently and economically operated hospitals; and
>
> 3) applies rates which fail to adequately take into account the circumstances of hospitals which serve a disproportionate number of low income patients with special needs.

Pet. App. 53a, 91a-92a. The court ordered the Commonwealth to "take all necessary steps to bring the Pennsylvania Medical Assistance Plan into compliance with federal requirements." *Id.*

On February 21, 1990, the District Court awarded interim relief to Temple to prevent the irreparable loss that Temple would otherwise suffer pending the Commonwealth's development of a new state plan. In exercising its equitable powers, the court took great pains "to

establish an interim payment level based upon eliminating only the most obvious and clear-cut inadequacies of the present plan."[8] Pet. App. 97a. *See also* Pet. App. 39a.

Hospitals in the four related cases filed various motions for summary judgment and interim relief. Pet. App. 16a. On March 1, 1990, the District Court entered an order granting permanent injunctive relief[9] in each of those pending cases "for the reasons stated in this court's rulings on interim relief in [*Temple*] (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features)." Pet. App. 105a-112a. The Order was "without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications."

On May 16, 1991, after oral argument but before a decision had been rendered by the Court of Appeals, the Commonwealth, HAP, and all hospital respondents entered into a Stipulation of Settlement. Pet. App. 17a, n. 5. Pursuant to the Stipulation, the parties agreed to place in civil suspense all litigation pending before the District Court. *Id.* All hospital respondents except Temple have pending motions for additional relief before the district

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[8] The court's award of increased payments to the hospitals was, in all cases, subject to repayment (or offset against future payments) in the event that the hospitals were not ultimately entitled to them under the Commonwealth's revised Medicaid plan. Pet. App. 28a, 102a.

[9] *See* Pet. App. 33a and n.7 for the Third Circuit's analysis of the proper classification of the relief awarded as permanent injunctive relief.

court.[10] These motions have not yet been resolved, and as a result of the Stipulation, may never have to be resolved.

The Court of Appeals acknowledged the "conditional nature of the settlement" and found that the appeals had not been mooted. Pet. App. 17a-18a. On July 30, 1991, the Court of Appeals affirmed the District Court's orders in the consolidated hospital cases. Pet. App. 1a.

The Petition for Certiorari followed.

REASONS FOR DENYING THE WRIT

Wilder was correctly decided, but even assuming, _arguendo_ that it was wrong, principles of _stare decisis_ dictate against overruling it.

This Court should deny petitioners' invitation to re-examine its decision in *Wilder* that the Boren Amendment is enforceable under 42 U.S.C. § 1983. Certainly, there was no disagreement among the Courts of Appeals prior to this Court's deciding that issue. Each of the federal appellate courts which had previously considered this issue had determined that providers have such a cause of action to enforce the Boren Amendment in federal court.

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[10] Some of these motions seek relief from inadequate disproportionate share payments.

Wilder, ___ U.S. at ___ n.14 and ___ n.16, 110 S.Ct. at 2521 n.14 and 2522 n.16 (citing cases).[11]

We believe it absolutely clear that the *Wilder* decision was correctly decided.[12] However, even assuming, as petitioners do, that this was not the case, principles of *stare decisis* dictate that the Court should not overrule *Wilder* at this time. The words of Justice Brandeis are pertinent here.

> *Stare decisis* is usually the wise policy, because in most matters it is more important that the applicable rule of law be settled than that it be settled right . . . . This is particularly true even where the error is a matter of serious concern, provided correction can be had by legislation . . . .

Burnet v. Coronado Oil & Gas Co., 285 U.S. 393, 406-408 (1932) (Brandeis J. dissenting). *See also Illinois Brick Co. v. Illinois*, 431 U.S. 720, 736-737 (1977), *reh den* 434 U.S. 881 (1977); *Runyon v. McCrary*, 427 U.S. 160, 175 (1976); *Edelman v. Jordan*, 415 U.S. 651, 671 (1974), *reh den* 416 U.S. 1000 (1974).

Petitioners contend that principles of *stare decisis* have less force in this case than in most. However, in making that argument, petitioners mischaracterize the

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[11] The conclusion that *Wilder* was decided correctly is further buttressed by the failure of Congress to change the statute in light of that decision.

[12] Respondents respectfully reserve analysis of the substance of the *Wilder* decision for their brief on the merits, in the event such filing is necessary.

nature of the issue at hand by casting the question as one raising "quasi-constitutional" issues. Pet. Br. at 18. Later, when arguing the merits of the issue, petitioners more accurately describe the question as one of "statutory" construction. Pet. Br. at 19.

Petitioners' confusion notwithstanding, the underlying issue in this case is the proper interpretation of the Social Security Act. This Court has previously recognized that cases arising under Section 1983 which seek enforcement of the Social Security Act are "statutory cases." *Golden State Transit Corp. v. City of Los Angles*, 493 U.S. 103, 118 (1989) (Kennedy, J. dissenting).

In *Golden State Transit*, the Court identified the proper inquiry as follows:

> In all cases, the availability of the § 1983 remedy turns on whether *the statute*, by its terms *or as interpreted*, creates obligations "sufficiently specific and definite" to be within "the competence of the judiciary to enforce", . . . is intended to benefit the putative plaintiff, and is not foreclosed "by express provision or other specific evidence from the statute itself."

Golden State Transit, 493 U.S., at 108 (citations omitted) (emphasis added). Thus, it should be clear that the issues presented here are statutory, and not quasi-constitutional, and that the standard rules of *stare decisis* apply.

A. Statutory precedents should not be overruled absent compelling justification, which petitioners have failed to demonstrate.

Overruling *Wilder* would be an affront to the principle that considerations of *stare decisis* are to be given particularly strong weight in the area of statutory construction because Congress may alter what the Court has done by amending the statute. In constitutional cases, by contrast, Congress lacks this option, and an incorrect or outdated precedent may be overturned only by the Court's reconsideration or by constitutional amendment. *Patterson v. McLean Credit Union*, 491 U.S. 164, 175, n.1 (1989).

Petitioners have failed to meet the high burden which this Court has traditionally imposed on the party asking the Court to reverse itself on an issue of statutory construction. *Patterson*, 491 U.S., at 172 (citing cases). In *Patterson*, the Court identified several circumstances which might justify reversing statutory precedents. None of those circumstances are present in the instant case.

The Court noted the primary reason for reconsidering a statutory interpretation is the intervening development of the law, through either the growth of judicial doctrine or further action taken by Congress. 491 U.S. at 173. There has been no such intervening development of the law in the approximately eighteen (18) months since *Wilder* was decided.

Another circumstance identified by the Court is the situation where a precedent may be a positive detriment to coherence and consistency in the law, either because of inherent confusion created by an unworkable decision, or

because the decision poses a direct obstacle to the realization of important objectives embodied in other laws. *Id.*, citing cases. *Wilder* poses no such detriment. It has created no confusion. Nor has it posed a direct obstacle to the realization of important objectives. Rather, it simply affirmed the rulings of every federal appellate court that had considered the issue.

The final justification cited in *Patterson* for overruling statutory precedent is simply not applicable to *Wilder*. "[A] precedent becomes more vulnerable as it becomes outdated and after being 'tested by experience, has been found to be inconsistent with the sense of justice or with the social welfare.' " *Id.* (citations omitted). A decision less than two years old can hardly be considered outdated or tested by experience.

In the short time since *Wilder* was decided, there has been no controversy or confusion surrounding the *Wilder* holding as it applies to litigation arising under the Boren Amendment. *Compare Afroyim v. Rusk*, 387 U.S. 253, 255-56 (1967) (overruling a ten year old Supreme Court decision that had been decided by a 5-4 vote, described as being "a source of controversy and confusion ever since"); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 47-49 (1977) (overruling a ten year old Supreme Court decision citing continuing controversy and confusion both in journals and in courts and noting that a number of courts have sought to limit the reach of the earlier decision). Indeed, notwithstanding *Wilder*, the number of Boren Amendment cases has actually declined. Petitioners cite only thirteen Boren Amendment cases against nine states, in contrast to the thirty-one actions pending against eighteen states cited by amici during the *Wilder*

deliberations.[13] Thirteen cases can hardly be classified as a "torrent." Pet. Br. at 26.

As Justice Harlan observed, writing for a unanimous court in *Moragne v. States Marine Lines*, 398 U.S. 375, 403 (1970):

> Very weighty considerations underlie the principles that courts should not lightly overrule past decisions. Among these are the desirability that the law furnish a clear guide . . . ; the importance of furthering fair and expeditious adjudication by eliminating the need to re-litigate every relevant proposition in every case; and the necessity of maintaining public faith in the judiciary as a source of impersonal and reasoned judgments. The reasons for rejecting any established rule must be weighed against these factors.

Petitioners have not identified any compelling reason which, when weighed against the factors enunciated in *Moragne*, compel that *Wilder* be overruled.

In urging this Court to reverse itself and to adopt the minority view in *Wilder*, petitioners ignore the fundamental relationship between the judiciary and the legislature. Simply stated, reversal of *Wilder* at this time would usurp the right and power of Congress to amend the Social Security Act if Congress in fact disagrees with the Court's

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[13] *See* Appendix to the Brief Amici Curiae of the state of Connecticut, joined in by 46 states, including Pennsylvania. The thirteen cases cited here by petitioners and the thirty-one cited in *Wilder* by amici both include the five actions against the Commonwealth before this Court on this Petition.

interpretation of the statute in *Wilder*. Petitioners' complaint that the *Wilder* majority ignored the statutory language of the Social Security Act and "effectively converted the Medicaid Program into an entitlement program . . . for hospitals . . . " (Pet. Br. at 21) is best remedied by Congress, which has full authority to amend the statute if it is dissatisfied with prior judicial interpretations. *Patterson*.

B. Overruling *Wilder* would disrupt the even flow of justice and Congressional legislative activity.

Overruling *Wilder* less than eighteen (18) months after it was decided would undermine the evenhanded, predictable, and consistent development of legal principles, inhibit reliance on judicial decisions, and detract from the actual and perceived integrity of the judicial process. *Payne v. Tennessee*, ___ U.S. ___, 111 S.Ct. 2597, 2609 (1991), *reh den* ___ U.S. ___, 115 L.Ed.2d 1110 (1991). Furthermore, it would usurp the power of Congress, which has the legislative prerogative to amend the Social Security Act if it is dissatisfied with the Court's ruling. *Patterson*.

This deference to the legislative authority to amend the statute is particularly appropriate in the area of Medicaid. As petitioners concede, there has been much legislative activity in the area of Medicaid reimbursement. Pet. App. at 15, n.1, and 34. Congress is now considering two additional bills dealing with Medicaid. *See* H.R. 3595 (approved Oct. 23, 1991 by the House Energy and Commerce Subcommittee by a vote of 16 to 6), and S. 1886 (introduced Oct. 29, 1991 and referred to the Senate

Finance Committee). The Health Care Financing Administration (HCFA) also recently promulgated new Medicaid regulations which relate to Medicaid funding. *See* 56 Fed. Reg. 56132 (Oct. 31, 1991) (interim final rule with comment on provider donations and taxes) and 56 Fed. Reg. 56141 (Oct. 31, 1991) (proposed rule limiting definition of disproportionate share hospitals).

This is not an area where Congress, having acted, has walked away. If indeed the *Wilder* decision caused any of the ills of which petitioners complain, those ills are best cured by Congress and not by judicial reversal of that decision.[14]

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[14] If, notwithstanding the above arguments, the Court feels that *Wilder* should be reexamined, respondents respectfully suggest that this case is not a good vehicle for such action because of the uncertainties occasioned by (1) the parties' settlement, (2) the pending motions which are presently in civil suspense and (3) anticipated Congressional activity amending the Social Security Act.

CONCLUSION

For the foregoing reasons, respondents respectfully request that this Court deny petitioners' Petition for a Writ of Certiorari.

Respectfully submitted,

ROLAND MORRIS
(Counsel of Record)
ALLEN C. WARSHAW
PAULA GAYLE SANDERS

DUANE, MORRIS & HECKSCHER
305 North Front Street
P.O. Box 1003
Harrisburg, PA 17108-1003
(717) 238-8161

Counsel for Respondents,
The Hospital Association
of Pennsylvania, et al.

Dated: November 27, 1991

RESPONDENTS' RULE 29.1 DISCLOSURES[1]

The Hospital Association of Pennsylvania#; Allegheny Valley Hospital, Allegheny Valley Health System*; The Allentown Hospital, Healtheast, Inc.*; Allentown Osteopathic Medical Center, Community Systems, Inc.*; Altoona Hospital, Central Pennsylvania Health Services Corporation*; J.C. Blair Memorial Hospital#; The Bloomsburg Hospital, Bloomed Corporation*; Braddock Medical Center (formerly known as Braddock General Hospital), Heritage Health Systems, Inc.*; Bradford Hospital#; Brandywine Hospital, Brandywine Health Services, Inc.*; Brownsville General Hospital, Brownsville Health Resources, Inc.*; Bryn Mawr Hospital, Main Line Health, Inc.*; Butler Memorial Hospital, Butler Area Health Resources Development Corp.*; Cannonsburg General Hospital, Vanguard Health System, Inc.*; Carbondale General Hospital#; Carlisle Hospital, Carlisle Hospital and Health Services*; Central Medical Health Services, Inc. d/b/a Central Medical Center and Hospital, Central Medical Health Corporation*; The Chambersburg Hospital, Chambersburg Hospital Health Services*; The Chester County Hospital, The Chester County Hospital Foundation*, Turks Head Health Services, Inc.+, Hospital Home

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[1] For ease of reference, the following symbols have been used to indicate corporate structure:

# indicates no parent or non-wholly owned subsidiary corporation;

* indicates parent corporation;

+ indicates subsidiary corporation; and

@ indicates no parent with one or more subsidiaries

Healthcare and Community Services, Inc.+; Chestnut Hill Hospital, Chestnut Hill Hospital HealthCare*; Children's Hospital of Philadelphia, The Children's Hospital Foundation*; Citizens General Hospital, Citizens General Hospital Group*; Clarion Hospital, Clarion Health Systems, Inc.*; Clearfield Hospital, Clearfield Area Health Services Corporation*; Charles Cole Memorial Hospital#; The Community General Hospital, Reading#; Community General Osteopathic Hospital, Community General Osteopathic Hospital Foundation*; Community Hospital of Lancaster, Lancaster Osteopathic Healthcare Foundation*; Community Medical Center, Community Medical Center Foundation*; Conemaugh Valley Memorial Hospital, Medical Center Hospital Corporation@, JMRI Corporation @, Medical Building of Johnstown, Inc.@, Memorial Preferred Providers, Inc.@; Crozer-Chester Medical Center, Crozer-Keystone Health System*; Delaware Valley Medical Center#; Divine Providence Hospital of Pittsburgh#; Divine Providence Hospital of The Sisters of Christian Charity, Sisters of Christian Charity Health Care Corporation*; Doylestown Hospital, Village Improvement Association*; DuBois Regional Medical Center#; Easton Hospital, Valley Health*; The Ellwood City Hospital#; Ephrata Community Hospital, Ephrata Community Hospital Foundation*; Forbes Health System d.b.a. Forbes Metropolitan Health Center, Forbes Healthmark*; Forbes Health System d.b.a. Forbes Regional Health Center, Forbes Healthmark*; Franklin Regional Medical Center#; Franklin Square Hospital (formerly known as Metropolitan Hospital, Central)#; Frick Community Health Center, Frick Health System*;

Geisinger Medical Center, Geisinger Foundation*; Geisinger Wyoming Valley Medical Center, Geisinger Foundation*; The Gettysburg Hospital, Gettysburg Health Care Corporation*; Gnaden Huetten Memorial Hospital, CMS Hospital Care Corporation@; Good Samaritan Hospital, The Good Samaritan Health Services Foundation and Subsidiaries*; Grand View Hospital, Grand View Hospital Foundation*; Greene County Memorial Hospital#; Greenville Regional Hospital#; Hamot Medical Center, Hamot Health Systems, Inc.*; Hanover General Hospital, Hanover HealthCorp, Inc.*; Harrisburg Hospital, Capital Health System Services*; Hazleton-St. Joseph Medical Center#; Highlands Hospital and Health Center#; Hospital of Philadelphia College of Osteopathic Medicine, Osteopathic Medical Center of Philadelphia*; Hospital of Philadelphia College of Osteopathic Medicine – Parkview (formerly Metropolitan Hospital, Parkview), Osteopathic Medical Center of Philadelphia*; Indiana Hospital, Indiana Healthcare Corporation*; Jameson Memorial Hospital, Jameson Health System, Inc.*; Jeanes Hospital, Anna T. Jeanes Foundation*; Jeannette District Memorial Hospital, Jeannette Health Pace*; Jefferson Park Hospital, Thomas Jefferson University*; Jersey Shore Hospital, Jersey Shore Health Care, Inc.*; Andrew Kaul Memorial Hospital, Andrew Kaul Health System*; John F. Kennedy Memorial Hospital#; Kensington Hospital, Community Health Services Foundation*; The Lancaster General Hospital, The Lancaster General Hospital Foundation*; The Lankenau Hospital, Main Line Health, Inc.*; Lee Hospital, Lee Health Services*,

Walnut Management Corporation+, Johnstown Medical Development Corporation+, TriCounty Ambulatory Care Centers, Inc.+, Lee Health Services Foundation+; Lehigh Valley Hospital Center, Healtheast, Inc.*; The Lower Bucks Hospital, Lower Bucks Health System*, Smith-Kline BioScience Laboratories, Ltd.+; McKeesport Hospital, McKeesport Area Health Care Systems*; Meadville Medical Center, MMC Health Systems, Inc.*; The Medical Center, Beaver, PA., Inc., Consolidated Healthcare Services, Inc.*, The Medical Center HPJV, Inc.+; The Medical College of Pennsylvania, Allegheny Health Services (d.b.a Allegheny Education and Research Foundation)*, MCP Health Care Services, Inc.+; Memorial Hospital, Memorial Health Systems Corporation*; Memorial Hospital of Bedford County#; Mercy Catholic Medical Center, Fitzgerald, Mercy Health Corporation*; Mercy Hospital, Altoona, Sisters of the Holy Family of Nazareth of Western Pennsylvania*, Altoona Family Inc.+; Mercy Psychiatric Institute (formerly St. John's General Hospital), Pittsburgh Mercy Health System, Inc.*, The Mercy Center for Chemical Dependency Services (formerly Brighton Woods Treatment Center, Inc.)+; Methodist Hospital#; Metro Health Center#; Millcreek Community Hospital#; The Milton S. Hershey Medical Center of the Pennsylvania State University#; Monongahela Valley Hospital, Inc., Mon-Vale HealthResources, Inc.*; Montefiore University Hospital (successor by merger to Eye & Ear Hospital, Pittsburgh)#; Montgomery Hospital#; Muhlenberg Hospital Center@, Muhlenberg Realty

Corporation+; North Penn Hospital, North Penn Hospital Foundation*; Northeastern Hospital, Northeastern Hospital Foundation*; Paoli Memorial Hospital, Main Line Health Inc.*; Pennsylvania Hospital, The Contributors to the Pennsylvania Hospital*, Delancey Corporation+, The Counseling Program+; Phoenixville Hospital, Phoenixville Health Care Corp.*; Pocono Medical Center, Pocono Health System*; Pottstown Memorial Medical Center, Pottstown Healthcare Corporation*; Pottsville Hospital & Warne Clinic, Schuylkill Health Care Services, Inc.*; Punxsutawney Area Hospital, Punxsutawney Area Hospital, Inc.*, Jefferson Regional Health Services, Inc.+, Jefferson Imaging Associates, Inc.+; Quakertown Community Hospital, Lifequest*; The Reading Hospital & Medical Center, The Reading Hospital*; Roxborough Memorial Hospital, Roxborough Memorial Health Foundation*; Sacred Heart Hospital, Allentown, Sacred Heart Healthcare Systems*; Sacred Heart Medical Center@, Franciscan Health Services, Inc.+; St. Agnes Medical Center, Franciscan Healthcare Corporation*; St. Francis Medical Center, St. Francis Health System*; St. Joseph Hospital, Inc. (Lancaster), Franciscan Health System*; St. Joseph's Hospital@ (Carbondale), Northern Tier Mobile Services+; St. Joseph Hospital, Reading, Franciscan Health System*; St. Luke's Hospital of Bethlehem, PA, Horizon Health System, Inc.*; St. Margaret Memorial Hospital, St. Margaret Health System, Inc.*; St. Vincent Health Center, St. Vincent Health System*; Sewickly Valley Hospital#; Shadyside Hospital, Shadyside Health Education and Research Corporation ("SHERCORP")*; Sharon General Hospital@, Sharon Preferred

Provider Organization+, SGH Enterprises, Inc.+, Sharon Regional Physician Services+; Southern Chester County Medical Center, Southern Chester County Health Services*; Springfield Hospital (formerly Metropolitan Hospital, Springfield), Crozer-Keystone Health System*; Suburban General Hospital, Norristown, Suburban General Corporation*; Suburban General Hospital, Pittsburgh, Suburban Health Corporation*; Sunbury Community Hospital#; Taylor Hospital, Taylor Hospital Foundation*; Titusville Area Hospital, Titusville Area Health Center, Inc.*; Tyler Memorial Hospital, Tyler Clinic*; Tyrone Hospital#; The Uniontown Hospital, Uniontown Health Resources, Inc.*, The Uniontown Hospital Foundation+; The Washington Hospital, Washington Health Care Services, Inc.*; Wayne Memorial Hospital, Wayne Memorial Health System*; Westmoreland Hospital Association, Westmoreland Health System*; Wilkes-Barre General Hospital, Wilkes-Barre General Health Corporation*; The Williamsport Hospital and Medical Center, North Central Pennsylvania Health System*, Williamsport Area Ambulance Service Corporation+; York Hospital, York Hospital Foundation*.

(3)

No. 91-732

In The

Supreme Court of the United States

October Term, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY – OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF OF RESPONDENTS, ALBERT EINSTEIN MEDICAL CENTER, ET AL., IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JEFFREY B. SCHWARTZ
DAVID M. DORET
(Counsel of Record)
MARK H. GALLANT
WOLF, BLOCK, SCHORR and
SOLIS-COHEN
12th Floor, Packard Building
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

COUNTERSTATEMENT OF QUESTIONS PRESENTED

I. Whether this Court should overrule its own recent decision in *Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510 (1990), holding that the Boren Amendment is enforceable in an action brought by health care providers under Section 1983.

II. Whether the narrow ruling below on Medicaid disproportionate share adjustments constituted an abuse of discretion under the circumstances presented?[1]

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[1] A list of the respondents on whose behalf this brief in opposition is filed, along with the disclosures required by Sup. Ct. R. 29.1, is set out in the Appendix to this brief ("Resp. App.").

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF CITATIONS

BRIEF OF RESPONDENTS, ALBERT EINSTEIN MEDICAL CENTER, ET AL., IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

This brief in opposition to the Petition for Writ of Certiorari (the "Petition") is filed on behalf of respondents, Albert Einstein Medical Center, et al., appellees in the case *Albert Einstein Medical Center, et al., v. White, et al.*, No. 90-1203 (3d Cir.) (the "*Einstein* Appeal").

OPINIONS BELOW AND STATEMENT OF JURISDICTION

The opinions below are set out at page 1 of the Brief for Petitioners ("Pet. Br."), and are found in Petitioners' Appendix ("Pet. App."). The statement of this Court's jurisdiction is found in Pet. Br. at page 2.

COUNTERSTATEMENT OF THE CASE

This action began in 1988 when the Pennsylvania Department of Public Welfare ("DPW") issued rate notices to acute care hospitals participating in the Medicaid Program, setting forth their group "base" rates for reimbursement for the medical care they give to the medically indigent, and (for qualifying hospitals) the disproportionate share "add-on" rate designed to compensate a minority of hospitals (which so qualify) for the extra costs incurred in caring for high concentrations of indigent

patients.[2] Of the fifteen original *Einstein* plaintiff hospitals, three have since filed for bankruptcy. *See* Resp. App. at 2a. Plaintiffs brought suit to challenge the unlawful base rates announced by Pennsylvania for its Medicaid reimbursement to acute care hospitals, as well as (in the case of the qualifying hospitals) the unlawful disproportionate share add-ons.[3]

The case instituted by co-respondent Temple University Hospital ("Temple") was calendared for trial, and the plaintiffs in *Einstein* contemporaneously moved for summary judgment. The District Court subsequently determined, following the trial in *Temple*, that the group base rates violated both the procedural and substantive requirements of the Medicaid Act, as embodied in the "Boren Amendment."[4] Pet. App. 91a-92a. This ruling was based, *inter alia*, on the Court's determinations that Pennsylvania had effectively reduced the group rates in a

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[2] The Medicaid Program is a joint federal-state program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§1396, 1396(a)-1396(u). Congress has determined as a matter of legislative fact that significant additional costs are incurred by hospitals that treat a disproportionate number of indigent patients. Disproportionate share add-on adjustments designed to compensate such hospitals are governed by 42 U.S.C. §1396r-4(b).

[3] Under its Medicaid System, most general acute care hospitals were included in one of seven groups, each of which was assigned a prospective group-wide payment rate.

[4] The Boren Amendment sets forth requirements states must meet when setting the reimbursement rates to which hospitals, nursing homes and intermediate care facilities are entitled. 42 U.S.C. §1396a(a)(13)(A). *See also, Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510, 2513-2514, n.2 (1990).

manner that was not authorized under the terms of its then binding State Plan, and that DPW arbitrarily effected an across-the-board reduction – or "lop off" – solely to accomplish budgetary objectives. The Court further found that DPW never defined, let alone assessed, the costs that must be incurred by an efficiently and economically operated hospital – despite "assuring" HCFA that it had factually found that its rates were indeed adequate in this respect. The District Court also declared that the special disproportionate share add-on payment DPW had made to Temple was legally inadequate.

Having declared Pennsylvania's Medicaid rates unlawful, the District Court ordered DPW to construct a revised State Plan and to pay Temple an interim disproportionate share add-on equal to less than half of its Medicare disproportionate share add-on pending the State's adoption of a revised State Plan. After disposing of *Temple*, the District Court granted permanent injunctive relief as to the *Einstein* hospitals, requiring that their base rates be upwardly adjusted by approximately 14% to eliminate the unlawful "lop off" – which the District Court considered DPW's most clear cut and egregious error – pending adoption of the revised State Plan.

The United States Court of Appeals for the Third Circuit, having consolidated the cases on appeal, affirmed those rulings. Pet. App. 27a. Thereafter, the parties entered into a comprehensive stipulation of settlement which currently is in effect. Pet. App. 17a, n.5.

Petitioners do not urge that the lower courts erred in holding that DPW violated the Medicaid Act in promulgating the base rates (which account for the vast

majority of the Medicaid payments). Rather, Petitioners seek entirely to insulate their rate setting process from judicial review by challenging the very right of Respondents to institute actions in federal court. Petitioners seek a merits review only of the disproportionate share add-on adjustment.

This opposition to certiorari is submitted by the remaining twelve hospitals in the *Einstein* Appeal. These hospitals are predominantly inner-city institutions treating high concentrations of the medically indigent. While the *Einstein* Respondents join in the presentations by their respective co-respondents, they file this separate opposition to the writ to augment those presentations.

REASONS FOR DENYING THE WRIT

I. THE ARGUMENTS URGED BY PETITIONERS FOR REVIEW OF *WILDER* ARE BASED ON MISCONCEPTIONS AND IN IN FACT SUPPORT DENIAL OF REVIEW

Petitioners do not challenge the merits of the rulings below as to the base payment rates. Instead, they request the Court to overrule *Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510 (1990), a case decided scarcely eighteen months ago. In support of their request, three spurious propositions are advanced by Petitioners. When properly brought into focus, each of the propositions in fact supports denial of the writ.

A. It Is A Misconception For Petitioners To Suggest There Exists Meaningful Federal Agency Oversight As A Basis to Reconsider *Wilder.*

Petitioners rely heavily on purported oversight by the federal bureaucracy over state Medicaid reimbursement programs (Pet. Br. at 24, 28) as a basis for their Petition. However, the federal bureaucracy does little in the way of oversight. The flagrant agency abuse by Petitioners in this case – their failure to adhere to the most basic federal statutory and regulatory requirements – both proves that the argument urged by Petitioners is misconceived, and, by virtue of the highly case-specific conduct in question, makes this case inappropriate for review.

It is true that the states must submit a "State Plan" to the Health Care Financing Agency ("HCFA"), which must be reviewed and approved by HFCA as a condition to receiving federal matching funds under Title XIX. Under Title XIX, the State Plan represents the legally binding program for the state's reimbursement of providers (i.e., hospitals) for the provision of services to Medicaid patients. The statute also requires that the state make "findings" and provide "assurances" to HCFA that its State Plan complies with federal law, including that it affords "reasonable and adequate" reimbursement. HCFA, however, does not directly scrutinize the adequacy of State Plans; rather, as the Court below stated, HCFA "relies on the state's 'assurances' and does not independently evaluate the adequacy of the rates." Pet. App. 20a. By making sham "findings" and mechanical "assurances," the states can circumvent meaningful oversight.

This case presents the clearest such example. Petitioners egregiously broke the law in two ways. First, Petitioners employed a "lop off" factor (roughly 14%) to cut the reimbursement rates that would have been derived by adhering to the methodology actually set forth in Pennsylvania's own State Plan. Pet. App. 21a-22a. After calculating the rates in the fashion required by the State Plan, Petitioners then unlawfully reduced the rates called for by the State Plan by a so-called "budget neutrality factor" – the "lop off" – which had the effect of reducing the projected aggregate amount that would be paid to hospitals so that the amount would not exceed the previously-enacted budget appropriation. This "lop off" was found below to be in clear contravention of the State Plan and, thus, federal law. The Court below squarely noted that the "lop off" was solely "designed to restrict total MAP payments to the respective hospitals to the amount of the total inpatient budget appropriation for 1988-1989," Pet. App. 21a-22a, and affirmed its illegality.[5]

Having done this, Petitioners then proceeded to provide assurances to the federal government that Pennsylvania's rates were reasonable and adequate, and that they had made findings to support their assurances. Petitioners' assurances and findings, however, were fictitious. The District Court found that Petitioners made no findings based upon empirical studies as to critical areas relating to the matters for which assurances were

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[5] The interim relief granted below took into account the maximum adjustment that would have been allowed had DPW actually adhered to its State Plan.

required. The Court of Appeals squarely addressed Petitioners' failure to make findings:

> Thus, DPW had conducted no analysis and had made no findings as to the reasonableness or adequacy of its rates to cover the costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and varying percentage add-ons for disproportionate-share hospitals. Nor did DPW identify any findings which it made pertaining to "reasonable access to inpatient hospital care." Indeed, DPW admitted as much during pretrial discovery.

Pet. App. 25a-26a. The Court of Appeals then unanimously concluded that any "assurances" made by Petitioners were illusory:

> Without knowledge of hospital costs, DPW could not have known what an efficient and economical hospital operation would entail, let alone what payment rates would be reasonable and adequate to meet that hospital's costs and assure reasonable access to hospital care. In the absence of essential data and information, DPW was in no position to make findings, and clearly did not do so. Any assurances DPW made to the Secretary were, therefore, without foundation.

Pet. App. 27a.

The facts which underlie Petitioners' unlawful agency actions present unique and case-specific circumstances which, taken in their totality, create a record so devoid of merit for reversal that Petitioners have not even sought to challenge the determination that their base

rates violated the Medicaid statute. Given the unpromising record, and the overwhelming merits for affirmance, the present appeal is the last case in which *Wilder* should be reconsidered.[6]

B. Petitioners Are Disingenuous In Suggesting The Availability Of An Alternative State Remedy As A Basis To Reconsider *Wilder*.

Petitioners allude at some length to Pennsylvania's "extensive state administrative payment rate review process." Pet. Br. at 22. Petitioners fail to candidly address the severe shortcomings of that process in Pennsylvania; those shortcomings reinforce the inappropriateness of this case as an opportunity to reconsider *Wilder*.

Pennsylvania's state-level adjudicative processes are "nasty, brutish and short." It is true that hospitals in Pennsylvania may file administrative claims before the Office of Hearings and Appeals ("OHA"), Petitioners' captive tribunal, and then seek judicial review of the final administrative decision through appeal to the Commonwealth Court. *See* 55 Pa. Code §1101.84, 1 Pa. Code

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[6] This case is also particularly inappropriate for review since the parties have arrived at a settlement which is currently in effect. This court should not undertake review of cases in which the Court's ruling would effectively be meaningless. A settlement agreement has now been in effect for six months which provides that the base rates paid by Pennsylvania – higher than those which were directed by the District Court – will not be altered even if this Court were to grant certiorari and reverse, so long as the other completely ancillary conditions of the settlement remain in effect (as they have to this date). *See also* Section II(B) below.

§§35.1-35.251. But if the OHA hearing officer renders a decision with which DPW is dissatisfied, the Secretary of DPW has the right to unilaterally reverse that decision. Perhaps most importantly, Pennsylvania's administrative law precludes systemic challenges before OHA; a provider may only challenge the *application* of the methodology to that provider. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 30 (3d Cir. 1989), *cert. denied*, ___ U.S. ___, 110 S. Ct. 3213 (1990), *cert. granted and aff'd on other grounds*, ___ U.S. ___, 111 S. Ct. 1138 (1991); *cf.* Pet. Br. at 22.

Practical experience with DPW's administrative adjudication also teaches that on the whole, the process is fraught with delay and difficulty – obstacles which could prove fatal to the hospital seeking relief in view of the economic "cross-fire" in which many hospitals are being "trapped." *West Virginia University Hospitals, Inc. v. Casey, supra*, 885 F.2d at 14. A hospital, critically ill from Petitioners' toxic rate-making, could well expire on the OHA operating table in the hands of Petitioners' administrative officials.

Here, the "lop off" and fictitious "findings" and "assurances" infected the system itself, and would not have been subject to OHA review. Absent a federal court remedy, there existed no meaningful basis for the providers to have challenged the validity of the state's reimbursement methodology. Since system-wide deficiencies were at issue, and given the limitations imposed on the ability of Pennsylvania hospitals under the state's administrative procedures to challenge those deficiencies, this case presents atypical features making review of *Wilder* in this case inappropriate.

C. Petitioners Have Only To Fear Their Own Illegal Agency Action; They Can Hardly Be Heard to Complain That Suits By Providers Furnish A Basis To Reconsider *Wilder*.

While Petitioners wave the bloody shirt of a torrent of federal Medicaid litigation, they totally ignore the fact that this litigation resulted from a bald scheme by Petitioners to "lop off" roughly 14% from hospital reimbursement in direct contravention of Pennsylvania's self-prescribed (and binding) State Plan. Pet. App. 21a-22a. This illegality was compounded by provision of bogus "assurances" to HCFA respecting the reasonableness and adequacy of the rates which evolved from *sub silentio* changes to the approved State Plan methodology, and which, as both lower courts concluded, were not predicated on any analysis or studies of hospital costs or other considerations needed logically to support the "findings" explicitly required by federal statute and regulation. Given the extremity of the agency conduct which precipitated this case, Petitioners can hardly be heard either to complain about a torrent of Medicaid litigation or to argue that reconsideration of *Wilder* is here appropriate.

That the providers which were subjected to Petitioners' machinations should have sought relief in federal court is not surprising. As a matter of federal law, participating hospitals must treat the medically indigent; this requirement exposes them to ever-increasing economic distress as utilization rises, the cost of care increases and reimbursement rates decrease. Indeed, Petitioners *admitted* in the District Court that less than 20% of Pennsylvania's hospitals were being reimbursed for their reported costs as a result of DPW's *sub silentio* modification of the

rates prescribed under the State Plan. By this evasion of statutory funding responsibilities, Petitioners effectively sought to have the cost of medical care for the indigent subsidized by private hospital resources.[7]

States have little to fear if they avoid the temptation to evade compliance with statutory funding responsibilities and to deprive hospitals of their statutory rights. The fact is Petitioners disregarded their own State Plan, and gamed their reports to HCFA. Petitioners' suggestion that to shift reimbursement oversight from the federal bureaucracy to the federal courts "will have dramatic and potentially devastating repercussions upon the fiscal integrity of states which participate in the Medicaid Program" (Pet. Br. at 24) is truly a red herring. In fact, this lawsuit was about whether Petitioners would live up to the law, in particular the State Plan which Pennsylvania created and under which Pennsylvania was reimbursed by the federal government pursuant to a federal statute requiring Pennsylvania to observe the State Plan's terms. When Petitioners suggest that control over hospital costs is at issue, what Petitioners really are saying is that they should be left to their unfettered discretion to afford

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[7] It should also not be surprising that many hospitals, particularly urban hospitals treating heavy concentrations of the medically indigent, have been forced to seek bankruptcy protection or are teetering on the precipice of bankruptcy. *See* Resp. App. at 2a. This will inevitably and inexorably produce access crises, in contravention of the purpose of the Medicaid program. *See* 42 U.S.C. §1396a(a)(13); *contrast* Pet. Br. at 23 with Pet. App. at 89a. This problem is only exacerbated for the disproportionate share institutions whose concentration of medically indigent patients is recognized to make the cost of care even greater.

inadequate reimbursement as it suits Pennsylvania's budgetary goals. That Petitioners press so hard to deny a federal remedy speaks volumes about their true agenda – the opportunity to act with unfettered discretion and without effective and objective oversight.

The federal courts were properly held open to police Petitioners' abuse. In view of the agency conduct at issue, this case scarcely presents the occasion to consider otherwise.

II. PETITIONERS FAIL TO PRESENT A COMPELLING BASIS FOR REVIEW OF THE RULING ON THE DISPROPORTIONATE SHARE ADJUSTMENT

Petitioners also assert that this case presents important questions concerning the scope of the disproportionate share relief that federal courts may award against states under the auspices of the Boren Amendment. This is hardly the case. Rather, in an effort to underscore the alleged significance of the decision below, Petitioners have exaggerated the scope of the disproportionate share ruling. When that ruling is properly portrayed, it becomes clear that there exists no compelling basis to grant the writ.

A. The Decision That Petitioners Would Have This Court Review Is Not Of General Applicability But Is So Narrow As To Not Warrant Review.

In addition to invalidating Pennsylvania's base rates, the Courts below invalidated as inadequate the special

disproportionate share add-on payment (pursuant to 42 U.S.C. §1396r-4(c)) of 2.5% applied to co-respondent Temple.[8] Petitioners seek to challenge the merits only of the latter ruling, a ruling which applies to but a narrow corner of the Medicaid legislation. Petitioners then erroneously suggest that the Court of Appeals dispositively construed the Medicaid statute as it relates to disproportionate share add-ons, and that the Petition squarely raises important questions pertaining to the scope of this statutory provision.

Federal law expressly prescribes which hospitals are, at a minimum, "deemed" qualified to receive Medicaid disproportionate share adjustments. 42 U.S.C. §1396r-4(b). As they existed at the time Pennsylvania established the disproportionate share formula at issue, the statute and regulations afforded states the alternative of either (1) adopting an add-on based on the formula prescribed by Congress for analogous adjustments under the Medicare program under 42 U.S.C. §1396r-4(c)(1), or (2) developing a suitable alternative add-on formula under 42 U.S.C. §1396r-4(c)(2).[9]

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[8] As relief, Pennsylvania was ordered prospectively to devise its own replacement plan for disproportionate share adjustments, based on proper findings and assurances and consistent with the Medicaid statute. Pennsylvania was ordered to pay an additional amount, in the interim, only as to Temple.

[9] When Pennsylvania submitted its now invalidated and superseded adjustment formulas to HCFA, there existed only the two alternative approaches, now codified as 42 U.S.C. §1396r-4(c)(1) and (2). Congress added a separate formulation

(Continued on following page)

In striking Pennsylvania's 2.5% adjustment to Temple, the District Court grounded its decision on several bases. The Court partially rested its decision on the fact that the deviation between Pennsylvania's add-on percentage for Temple and that specifically authorized under the Medicare prong of §1396r-4(c)(1) was so great as to not even be in the same "ball park." The 2.5% adjustment, which was the maximum adjustment allowed by the state, was approximately *one-eighth* as much as the adjustment which would have been derived under the Medicare formulation.

The Court alternatively ruled, however, that the disproportionate share adjustment was invalid on grounds which did not turn on the meaning of the statute, invalidating Temple's 2.5% adjustment on the basis of gross procedural and other generic flaws infecting Pennsylvania's adoption of that adjustment. The District Court explained that the disproportionate share adjustment (like Pennsylvania's base rates) were adopted without any underlying findings or conclusions pertaining to its adequacy, and in contravention of the levels warranted under "defendants' own calculations." Pet. App. 79a, 80a. Rather, Pennsylvania had arbitrarily backed into

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under Section 4703(a) of the Omnibus Budget Reconciliation Act of 1990, P.L. No. 101-508, now codified as subsection 4(c)(3). Moreover, HCFA has recently proposed regulations to further modify the rules in this area. 56 Fed. Reg. 56132 (Oct. 31, 1991). The subsequent modification of the statute and HCFA's recent actions independently diminish any conceivable continuing significance of the decisions below.

adjustments ranging from 0.5% to 2.5% by "simply allocat[ing]" dollars to these adjustments based solely upon budgetary considerations having nothing to do with the actual added costs incurred by hospitals caring for a disproportionate share of low income patients. Pet. App. 80a-81a. These rulings clearly did not hinge on an interpretation of §1396r-4 at all.

Having so concluded, the District Court ordered Pennsylvania prospectively to devise and implement a proper disproportionate share adjustment as part of its revised state plan in compliance with §1396r-4 and, only on an interim basis, to pay Temple a 10% disproportionate share adjustment that was designed to prevent the hospital from suffering significant harm in its continuing treatment of a disproportionate share of indigent patients pending corrective action by DPW.[10] In awarding Temple a 10% adjustment purely as a form of interim relief, the District Court reasoned that it was fair beyond doubt to peg the add-on reimbursement for Temple temporarily at a level less than half of the amount that would be concededly payable if Pennsylvania had elected to adopt the first and most clear-cut disproportionate share approach authorized by Congress, as provided for under §1396r-4(c)(1). In so ruling, the District Court stressed

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[10] The District Court effectively granted permanent declaratory and injunctive relief to the *Einstein* Respondents and other hospitals to the extent that it ordered Pennsylvania to revise its state plan on a prospective basis. The claims of the disproportionate share *Einstein* Respondents for interim relief as to disproportionate share adjustments were resolved by the settlement, discussed in Section II(B) below.

that "the statute does not mandate any particular level of payments," and generally recognized that it afforded states "a considerable amount of flexibility." Pet. App. 81a, 82a. The District Court thus sent Pennsylvania "back to the drawing board" in the face of its multi-flawed disproportionate share approach, but did not determine dispositively the minimum adjustment that might properly be adopted by a state if supported by appropriate reasoning, findings and conclusions.

For apparent reasons, the Court of Appeals did not directly address the scope of §1396r-4(c)(2). Rather, the Court of Appeals simply sustained the District Court's ruling that the disproportionate share add-on payment to Temple was unlawful, and then found that an interim remedy crafted by the District Court and gauged at less than 50% of an amount clearly authorized by statute was not an abuse of discretion.

There is no decision by any of the Circuits to date which analyzes §1396r-4(c)(1) or (2). In the absence of a conflict on this issue, the narrow question of the proper standards for formulating a small portion of the overall Medicaid payments, to a minority of participating hospitals, would not be worthy of plenary review by this Court. Given, however, that this issue was never even reached by the Court of Appeals, this case is *a fortiori* unworthy of certiorari.

B. The Case Has Been Settled, And Further Review Would Essentially Be An Academic Exercise.

A settlement agreement was entered into during the pendency of this appeal and approved by and entered into the record of the District Court. This settlement agreement embodied negotiated rates that have already been *included* in a new State Plan submitted by Pennsylvania to HCFA, and approved. The new State Plan supersedes totally the State Plan which the District Court invalidated. Under the new State Plan, Petitioners have agreed to pay a far *higher* disproportionate share adjustment to Temple and the other qualifying hospitals than DPW was required to pay under the interim relief order (as to Temple) or than it would have paid generally (to the other qualifying hospitals) by applying the same formula. The fact that the parties have arrived at a settlement which provides for on-going payment of higher disproportionate share adjustments than were ordered by the lower court – and which would continue to be paid under the terms of the settlement agreement even if this court were to grant review and reverse – renders academic Petitioners' request for review, and makes this case inappropriate for certiorari.

Moreover, the current State Plan includes a schedule of disproportionate share adjustments and a formula which produces add-ons that closely approximate those that would be paid under the Medicare program prong of §1395r-4(c)(1). In Temple's case, this adjustment is significantly *higher* than the interim rates the lower courts approved. Given the obligations already undertaken by Petitioners, Petitioners should not be heard to complain

as to the affirmance of the interim disproportionate share adjustments below.

C. Review Should Be Denied Since The Statutory Issue Was In Any Case Correctly Decided Below.

Although the issue need not even be considered by this Court because the disproportionate share adjustment issue was decided and affirmed on appeal on far narrower alternative grounds, Pennsylvania's 0.5% to 2.5% disproportionate share adjustment brackets did not satisfy the requirements of §1396r-4(c)(2), and the District Court's alternative conclusion that the adjustment paid to Temple was substantively inadequate was in any case correct.

Petitioners effectively contend that the states were given unfettered discretion by Congress under 42 U.S.C. §1396r-4(c)(2) to adopt any disproportionate share add-on formula which provides for any adjustment amounts, however minimal, provided that qualifying hospitals are paid adjustments which, in some rough fashion, increase based on the degree by which their Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate. Pet. Br. at 31. Petitioners assert that imposing any greater burden on them violates the rule of *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17 (1981). This argument is disingenuous.

Petitioners' argument requires reading subsection (c)(2) in complete isolation, and divorced from the context of the inter-related provisions of §1396r-4(c). It is well established, however, that:

> A statute is passed as a whole . . . and is animated by one general purpose and intent. Consequently, each part or section should be construed in connection with every other part or section so as to produce a harmonious whole. Thus it is not proper to confine interpretation to the one section to be construed.

SANDS, 2A SUTHERLAND STATUTORY CONSTRUCTION §46.05 at 90 (4th ed. 1984) (footnotes omitted) *and cases cited therein; see United States v. Vogel Fertilizer Co.*, 455 U.S. 16, 24-26 (1982) (interpretation must have fidelity to overall statutory framework and legislative history); *National Muffler Dealers Ass'n, Inc. v. United States*, 440 U.S. 472, 477 (1979) (interpretation of subprovisions must be harmonized with statute's "origin and purpose").[11]

In the present case, the more generally worded provisions of subsection (c)(2) are properly construed by harmonizing that section with subsection (c)(1). As HCFA

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[11] In addition, where a general provision of a statute follows the enumeration of specific item, the general provision should be interpreted in a manner that is consistent with the provision more specifically enumerated. *Miami Heart Institute v. Sullivan*, 868 F.2d 410, 413 (11th Cir. 1989); *see Harrison v. PPG Industries, Inc.*, 446 U.S. 578 (1980). Petitioners' contention that the "alternative" approach authorized by subsection (c)(2) leaves the adjustment levels completely open to a state's discretion, and may be divorced from the Medicare formula touchstone referenced in subsection (c)(1), violates this principle as well.

has observed, under (c)(1), Congress specified not only that states might employ the federal Medicare percentage disproportionate share formula for reimbursing qualifying disproportionate share hospitals under Medicaid, but that when this election is made, that percentage figure must be multiplied by "[a]n amount *at least equal* to the . . . hospital's Medicaid operating costs." Emphasis added. *See* 55 Fed. Reg. 10078 (Mar. 19, 1990).[12] Thus, in authorizing states to use the Medicare formulation as one acceptable method for determining a Medicaid disproportionate share adjustment, Congress expressly created a floor, but did not erect a ceiling.

In light of established principles of statutory construction, Petitioner's construction of subsection (c)(2) makes little sense. Petitioners would attribute to Congress the intention of establishing alternative formulas, one of which contains a generous minimum payment standard but another of which, for no apparent reason, would authorize states to completely circumvent that standard. Such an approach would render the floor incorporated into subsection (c)(1) a logical nullity. The far

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[12] Under §1396r-4(c)(1), states were given the option of applying the Medicare program disproportionate share percentage adjustment to the Medicaid "operating costs" otherwise being paid to participating hospitals that do not treat a disproportionate share of indigent patients (which "operating cost" payments might take a variety of forms, running the gamut from a fixed prospective payment rate to an actual cost-based reimbursement rate). If a state elects to use the Medicare percentage formula, it is not permitted under the statute to apply that formula to an amount which is *less* than the operating costs it reimburses participating hospitals generally under its Medicaid program.

more plausible interpretation is that Congress intended the alternative formula to produce an amount which is no less than the product of the Medicare disproportionate share adjustment and the state's standard operating costs.[13]

Given the palpable infirmities of Petitioners' position, the case was correctly decided below, and review is therefore inappropriate for this additional reason.

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[13] This interpretation is directly supported by the legislative history. Congress cited as its sole "example" of an add-on qualifying under the alternative formula of subsection (c)(2) the approach adopted by the State of Tennessee. In Tennessee, disproportionate share adjustments range from 6 to 34% above the base payment rates, and on the average produce rates 30% to 40% higher than those paid to non-disproportionate share facilities. *See* H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 526-527 (Oct. 26, 1987). These amounts range far above the maximum disproportionate share percentage amounts recognized by Medicare. Accordingly, as illuminated by this legislative history, Congress intended to use the Medicare formulation as a minimum amount, rather than to countenance a parsimonious alternative to the Medicare formula of the sort advocated by Petitioners.

CONCLUSION

For the reasons stated above, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

JEFFREY B. SCHWARTZ
DAVID M. DORET (Counsel of Record)
MARK H. GALLANT
WOLF, BLOCK, SCHORR AND SOLIS-COHEN
12th Floor, Packard Building
Philadelphia, PA 19102
(215) 977-2000

Attorneys for Respondents

APPENDIX

1. All Respondents are corporations. Pursuant to Sup. Ct. R. 29.1, the following list identifies all parent companies and subsidiary companies, aside from wholly-owned subsidiaries, with which each Respondent is affiliated.

Albert Einstein Medical Center's parent company is Albert Einstein Healthcare Foundation.

Allegheny General Hospital's parent company is Allegheny Health Services, Inc.

Episcopal Hospital's non-wholly owned subsidiaries are VHA-East, Inc., Health Partners of Philadelphia, and Somerset Villas, Inc.

Germantown Hospital and Medical Center's parent company is the Germantown Medical Center Foundation. Germantown Hospital and Medical Center's non-wholly owned subsidiaries are GHC Services, Inc., and GHMC Management, Inc.

Magee Womens Hospital's parent company is Magee Womens Health Corporation.

Mercy Catholic Medical Center-Misericordia Division's parent company is Mercy Health Corporation.

Mercy Hospital of Pittsburgh's parent company is Pittsburgh Mercy Health Systems, Inc.

Montefiore Hospital's parent company is Presbyterian University Health Systems, Inc.

Presbyterian University Hospital's parent company is Presbyterian University Health Systems, Inc.

St. Christopher's Hospital for Children's parent company is Allegheny Health Services, Inc.

Western Pennsylvania Hospital's parent company is Western Pennsylvania Healthcare System, Inc. Western Pennsylvania Hospital's non-wholly owned subsidiaries are West Pennsylvania Foundation, West Pennsylvania Corporate Medical Services, and West Pennsylvania Care.

2. Children's Hospital of Pittsburgh has no parent or non-wholly owned subsidiary company.

3. Three hospitals designated by Petitioners as Respondents, Guiffre Medical Center, St. Joseph's Hospital and St. Mary Hospital, are no longer participants in the group of hospitals represented herein. St. Mary Hospital declared bankruptcy, obtained separate representation, and settled its claims against Petitioners. Guiffre Medical Center became Girard Medical Center, subsequently declared bankruptcy, has been reorganized as North Philadelphia Health Systems, and has settled its claims against Petitioners. St. Joseph's Hospital declared bankruptcy and has been represented separately in the proceedings below.

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(4)

No. 91-732

In The

Supreme Court of the United States

October Term, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY – OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF IN OPPOSITION OF RESPONDENT TEMPLE UNIVERSITY – OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION

Of Counsel:

GEORGE E. MOORE, ESQUIRE
University Counsel
Temple University
435 Carnell Hall
Broad and Montgomery
Avenue
Philadelphia, PA 19122

MATTHEW M. STRICKLER*
LAURIE MARTIN
BALLARD SPAHR ANDREWS
& INGERSOLL
1735 Market Street
51st Floor
Philadelphia, PA
19103-7599
(215) 665-8500

*Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether a hospital has a private cause of action under 42 U.S.C. § 1983 to compel State officers to comply with two requirements of the Medicaid Act for payment rates for inpatient hospital care:

> (a) the requirement of 42 U.S.C. § 1396a(a)(13)(A) and 42 U.S.C. § 1396r-4 that States take into account the situation of hospitals serving a disproportionate share of indigent patients; and
>
> (b) the requirement of 42 U.S.C. § 1396a(a)(13)(A) that rates be reasonable and adequate to meet the costs of efficiently and economically operated hospitals.

2. Whether a State can comply with the "disproportionate share" hospital requirement of the Medicaid Act by increasing its payments up to a maximum of 2.5% when that State's data establish that hospitals with the largest indigent patient loads have costs more than 16% higher than otherwise comparable hospitals.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

Page

ADDITIONAL STATUTORY PROVISIONS INVOLVED

The Petition omits significant portions of 42 U.S.C. § 1396r-4 involved in this case. That Section reads in relevant part as follows:

(a) IMPLEMENTATION OF REQUIREMENT

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that –

> (A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section, which meets the requirement of subsection (d) of this section), and
>
> (B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

* * *

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirement of subsection (d) of this section is deemed to be a disproportionate share hospital if –

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

* * *

(c) PAYMENT ADJUSTMENT

In order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either –

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in

subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that –

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients.

Respondent Temple University – of the Commonwealth System of Higher Education[1] ("Temple") respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Third Circuit's decision.[2] That decision is reported at 941 F.2d 201 (1991).

COUNTERSTATEMENT OF THE CASE

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-1396u (the "Medicaid Act") provides federal financial participation for payments under State Medicaid programs that comply with that Act. Prior to 1981, the Medicaid Act required States to pay hospitals for inpatient care on the basis of the hospitals' reasonable costs. In 1981, Congress extended to hospitals what is commonly called the Boren Amendment. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173,

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[1] Temple is a Pennsylvania non-profit corporation which has been legislatively designated as state-related but which operates independently of state government under the direction of its board of trustees. 24 Pa. Cons. Stat. Ann. §§ 2510-1 to 12 (Supp. 1991). Temple has no subsidiaries that are not wholly-owned and no parent corporation.

[2] The five actions before this Court on the Petition are *Temple University – Of the Commonwealth System of Higher Education v. White, et al.*, Nos. 90-1112 and 90-1244 (3d Cir.) and C.A. 88-6646 (E.D. Pa.); *Frankford Hospital v. White, et al.*, No. 90-1204 (3d Cir.) and C.A. 88-08927 (E.D. Pa.); *Albert Einstein Medical Center, et al. v. White, et al.*, No. 90-1203 (3d Cir.) and C.A. 88-08831 (E.D. Pa.); *Hahnemann University Hospital, et al. v. White, et al.*, No. 90-1205 (3d Cir.) and C.A. 88-09132 (E.D. Pa.); and *Hospital Association of Pennsylvania, et al. v. White, et al.*, No. 90-1206 (3d Cir.) and C.A. 88-09848 (E.D. Pa.).

95 Stat. 357, 808-09 (1981) (codified at 42 U.S.C. § 1396a(a)(13)(A)). The actions before this Court involve two requirements of the Medicaid Act, as modified by the Boren Amendment: (1) payment rates for inpatient care must "take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs," and (2) a State must find and make assurances to the Secretary of Health and Human Services that those rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. §§ 1396a(a)(13)(A), 1396r-4. The House Conference Report for the Boren Amendment described both of these requirements but emphasized the requirement relating to "disproportionate share" hospitals by noting their "atypical costs" and then stating:

> The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.

H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1, 1324.[3]

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[3] In later enacting section 1396r-4, the House Budget Committee described Congressional concern for hospitals with high Medicaid volumes in similar terms:

> The purpose of this requirement . . . was to assure that, precisely because States were given flexibility in establishing payment rates, that those payment

(Continued on following page)

The "disproportionate share" hospital requirement has been the subject of Congressional action on six occasions since it was enacted in 1981. In 1985, Congress required the Secretary of Health and Human Services to provide a report on the methods used by States for their compliance with this requirement. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9519, 100 Stat. 82, 216-17 (1986).[4] After the Secretary submitted that report, the House Budget Committee concluded that there had been a "startling record of noncompliance [reflecting] the indifference, if not hostility, of HCFA and many of the States to the 1981 statutory

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> rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable. These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace.

H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-344.

[4] In the interim, the Health Care Financing Administration attempted to challenge a generous disproportionate share adjustment proposed by Georgia. Congress responded in 1986 by clarifying that HCFA has no authority to limit the payment adjustments to disproportionate share hospitals. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9433, 100 Stat. 1874, 2068 (1986) (codified at 42 U.S.C. § 1396a(h)).

requirement [for 'disproportionate share' hospitals]."[5] As a result, Congress amplified that requirement by enacting Section 1396r-4, which became effective July 1, 1988. Section 1396r-4 had two important requirements. First, the Section defined "disproportionate share" hospitals as including at least those hospitals at least one standard deviation above the mean Medicaid inpatient utilization rate and those hospitals with low-income utilization rates of greater than twenty-five percent. A state might classify more hospitals as "disproportionate share," but it could not classify fewer. 42 U.S.C. § 1396r-4(a)(1), (b). Second, a State was required to make "appropriate increases" in payments to "disproportionate share" hospitals using either (a) the formula used for Medicare reimbursement, or (b) a formula which the State developed providing for a minimum payment (or increased percentage payment) as well as an increase in that payment or percentage "in proportion to the percentage by which the hospital's medicaid utilization rate . . . exceeds one standard deviation above the statewide mean." 42 U.S.C. § 1396r-4(a)(2), (c). The House Budget Committee described what it had in mind if a State elected not to use the Medicare formula:

> The Tennessee approach offers an example of what the Committee intends for an alternative payment adjustment. In Tennessee, disproportionate share hospitals are defined by volume. For every 1,000 Medicaid days over 4,000 Medicaid patient days, hospitals receive a 6 percent increase in their payment rate for inpatient services, up to a maximum increase of 34 percent.

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[5] H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 525 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-345.

H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 526 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-346.

Section 1396r-4 has been amended three times since 1987. Most recently, the 1990 amendment added Section 1396r-4(c)(3), which permits a State, if it chooses, to vary its "disproportionate share" payments for different hospital types and to have an adjustment "that is reasonably related to the costs, volume, or proportion of services provided to [Medicaid] patients." Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4703, 104 Stat. 1388-171 (1990) (codified at 42 U.S.C. § 1396r-4(c)(3)).[6]

Clarification of the "disproportionate share" hospital requirement continues to the present time. On October 31, 1991 (three days after the Petition was filed), HCFA published an interim final regulation which would limit the number of hospitals that States could classify as qualifying for "disproportionate share" payments. In its published notice, HCFA stated its intention to publish soon still another interim final regulation "establishing specific disproportionate share hospital payment requirements." 56 Fed. Reg. 56141, 56143 (1991).

2. Respondent Temple operates Temple University Hospital, the largest provider of hospital services under the Pennsylvania Medicaid Program. The area of North Philadelphia surrounding Temple University Hospital is

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[6] This amendment was enacted after the decision of the District Court. The Court of Appeals was advised of the change by letter from Respondents' counsel under Federal Rule of Appellate Procedure 28(j). Although they do so here, Petitioners did not rely on this amendment in their briefs or argument to the Court of Appeals.

largely black and hispanic and has a substantial indigent population. About half the admissions to Temple University Hospital are eligible for Medicaid, another twenty percent (also largely indigent) are covered by Medicare, and about five percent have no source of payment whatsoever. Temple University Hospital deals with all of the severe health problems of the poor neighborhoods in American cities, including the effects of crime, drug addiction, and untreated medical conditions. In each of the five fiscal years from 1985 through 1989, Temple lost between $2.5 and $7.5 million treating Medicaid inpatients. Temple achieved some cross-subsidization from treating non-Medicaid patients but still lost $3.2 million on inpatient care in fiscal 1989. Temple incurred these losses notwithstanding that it was, as the District Court found, efficiently and economically operated. (Pet. App. 65a). Temple University Hospital is a classic example of the "disproportionate share" hospital which the requirements of the Medicaid Act were intended to protect. It is heavily dependent on the adequacy of payments under the Pennsylvania Medicaid Program.

3. In August of 1988, Respondent Temple brought an action in the United States District Court for the Eastern District of Pennsylvania alleging that the payment rates for inpatient hospital care under the Pennsylvania Medicaid Program violated both of the above requirements of the Medicaid Act. The other hospitals that are Respondents in this Court brought separate actions in November and December of 1988 raising substantially similar issues. The subsequent cases were assigned to the same District Judge as Temple's action but

have never been consolidated with that action in the District Court.

4. Temple's action was tried in June of 1989 and decided by the District Court in January of 1990. In a series of rulings, the District Court found that Petitioners had made no real effort to comply with the procedural requirements of the Medicaid Act and that the payments for inpatient hospital care violated that Act. The principal rulings were:

> (a) The rate levels were not "reasonable and adequate" to meet the necessary costs of efficient hospitals but "entirely budget-driven" and "arbitrary" (Pet. App. 78a);
>
> (b) Petitioners established the amount of the additional payments to "disproportionate share" hospitals by allocating the funds deemed available for that purpose. The additional payment to Temple was "only a small fraction of the total increase in costs attributable to Temple's status as a disproportionate-share hospital" (Pet. App. 79a, 80a); and
>
> (c) Petitioners merely certified to the Secretary of Health and Human Services that the rates complied with the Medicaid Act without making any empirical studies to support the assurances (Pet. App. 84a-85a).

5. Based on these and related findings, the District Court issued an injunction directing the Petitioners to bring their Program into compliance. The District Court was careful not to insist that Petitioners establish any particular rate structure, but did direct them to increase cash payments to Temple pending revision of the Program. The District Court also directed Petitioners to

increase payments to other Respondents pending revision of the Program to the extent that the reason for the increased payments to Temple applied "to all hospitals, without regard to their classification or other individual distinguishing characteristics." (Pet. App. 105a, 107a, 109a, 111a).[7] These increased payments were subject to repayment (or offset against future payments) if the hospitals were not entitled to them under the revised Medicaid Program.

6. Petitioners appealed each of these Orders. After consolidating the appeals, the Third Circuit affirmed the orders of the District Court in all respects. The Third Circuit emphasized that Petitioners had conducted no analysis to determine the reasonableness or adequacy of these rates and no analysis to determine the effect on a hospital of the disproportionate add-on payments. (Pet. App. 25a-26a). The Third Circuit relied on the testimony of Petitioners' principal trial witness that they did not "know, today, what hospital costs are" and concluded that, since Petitioners had no knowledge of hospital costs, their assurances of their compliance with the Medicaid Act were "without foundation." (Pet. App. 26a-27a).

7. Before decision by the Third Circuit, the parties entered into a Stipulation of Settlement under which they agreed to settle any dispute over payments for the effective period of the Stipulation, to place the actions in the District Court in civil suspense and to engage in a series

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[7] The other Respondents still have applications for relief pending in the District Court.

of pooling transactions[8] to enable Petitioners to pay higher rates. The parties believe that pooling transactions already completed will enable Petitioners to pay the higher rates, and will enable the Stipulation of Settlement to remain in effect, until June 30, 1992. The Stipulation provides that, if the parties can continue to engage in pooling transactions so that the Stipulation remains in effect until July 1, 1993, they will then dismiss each of the actions pending in the District Court.

8. On October 28, 1991, Petitioners filed this Petition seeking review of the decision of the Court of Appeals.

REASONS WHY THE PETITION SHOULD BE DENIED

I. INTRODUCTION AND SUMMARY

Respondent Temple brought this action to challenge the particular method by which Pennsylvania established its Medicaid rates for Temple University Hospital, an inner-city medical school hospital with the state's highest Medicaid volume. The lower courts were constrained to rule in Temple's favor by Pennsylvania's failure to make even a good faith effort to comply with the Medicaid Act and by the resulting discrepancies between Pennsylvania's Program and that Act. The District Court granted limited relief to the other Respondent hospitals because

[8] A pooling transaction allows the use of private donated funds as the State's share of Medicaid payments as permitted by 42 C.F.R. § 433.45(b).

the discrepancies applied in part "to all hospitals, without regard to their classification or other individual distinguishing features." (Pet. App. 105a, 107a, 109a, 111a).

Now, in an effort to find some question deserving of this Court's attention, Petitioners urge this Court to reconsider and overrule its recent decision in *Wilder v. Virginia Hospital Association*, 110 S. Ct. 2510 (1990). There is no special justification for such action. In any event, this case would present a poor vehicle for such action, given: (1) Petitioners' total failure to comply with the procedural requirements of the Medicaid Act; (2) the peculiar issues presented by the application of the Medicaid Act and the Pennsylvania Program to Temple; and (3) the possibility that these actions may be dismissed pursuant to a Stipulation of Settlement among the parties.

To their request to reconsider and overrule *Wilder*, Petitioners add a question concerning the requirement of the Medicaid Act for "disproportionate share" hospitals. This second question is of such limited application as to be unworthy of this Court's attention.

II. THERE ARE NO SPECIAL CIRCUMSTANCES TO WARRANT THIS COURT REEXAMINING ITS INTERPRETATION OF THE MEDICAID ACT.

The Petition asks this Court to reconsider its holding of less than two years ago, in *Wilder v. Virginia Hospital Association*, that health care providers have the right under 42 U.S.C. § 1983 to seek injunctive relief against State officers to enforce the Medicaid Act. The Petition argues that *Wilder* should be reconsidered and overruled because: (1) *Wilder* has begun to "unleash" a "torrent" of

provider challenges to state Medicaid programs; (2) it subjects state Medicaid rates to multiple attacks in multiple fora; and (3) *Wilder* was incorrectly decided.

This Court has held that " 'any departure from the doctrine of *stare decisis* demands special justification.' " *Patterson v. McLean Credit Union*, 109 S. Ct. 2363, 2370 (1989) (*quoting Arizona v. Rumsey*, 467 U.S. 203, 212 (1984)).

> We have said also that the burden borne by the party advocating the abandonment of an established precedent is greater where the Court is asked to overrule a point of statutory construction. Considerations of *stare decisis* have special force in the area of statutory interpretation, for here, unlike in the context of constitutional interpretation, the legislative power is implicated, and Congress remains free to alter what we have done.

Patterson, 109 S. Ct. at 2370. There is no special justification for departing from this Court's holding in *Wilder* so shortly after it was decided.

Contrary to the Petition, *Wilder* has not "unleashed" a "torrent" of provider actions challenging Medicaid payment rates. Rather, the evidence is that provider actions have decreased since *Wilder*. Pennsylvania and forty-five other states argued in *Wilder* that decisions by the Courts of Appeals had resulted in an "explosion" of litigation, pointing to thirty-one actions then pending against eighteen states.[9] In the present Petition, Pennsylvania points to

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[9] Brief Amici Curiae of the States of Connecticut, et al. at vii and Appendix, *Wilder*.

only thirteen actions against nine states.[10] At a time when more than twice as many actions were pending, this Court in *Wilder* considered and rejected the argument that allowing Medicaid providers to enforce State obligations under the Medicaid Act would burden the courts and the States with numerous challenges to Medicaid rates.[11] The few actions cited in the Petition do not constitute special circumstances that would warrant reconsideration of *Wilder.*

The Petition also argues that *Wilder* should be reconsidered because it subjects State Medicaid rates to multiple attacks in multiple fora. The Petition does not, however, identify any method of attack or any forum that has become available since *Wilder.* Review by the Secretary of Health and Human Services is not effective since, as the parties stipulated in this case, the Secretary does not normally look behind the findings and assurances given by the State. The Secretary normally accepts them at face value. Review in State administrative proceedings is similarly ineffective:

> The regulations allow States to limit the issues that may be raised in [a State] administrative proceeding. 42 C.F.R. § 447.253(c) (1989). Most States . . . do not allow health care providers to

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[10] In counting the number of pending actions cited in the list of the amici in *Wilder* and in the list in the Petition, we have included the five actions before this Court on this Petition.

[11] The number of Medicaid lawsuits is probably decreasing because the courts have accorded substantial deference to the States in developing Medicaid payment systems. *See, e.g., Wilder,* 110 S. Ct. at 2523 n.18.

> challenge the overall method by which rates are determined.

Wilder, 110 S. Ct. at 2524-25.[12] An action in federal court is a health care provider's only remedy for a State violation of the Medicaid Act. States are not subject to multiple attacks in multiple fora; rather, if *Wilder* is reversed, State Medicaid rates will be wholly insulated from provider challenges.

Since *Wilder* was decided less than eighteen months ago, Congress has amended the Medicaid Act as part of the Omnibus Budget Reconciliation Act of 1990. In amending the Medicaid Act, Congress declined the opportunity to nullify or alter *Wilder*. Similarly, there has been no intervening development of the law which has removed the conceptual underpinnings of *Wilder*, no new doctrines or policies that compete with *Wilder*, no evidence that *Wilder* is unworkable, and no evidence that it is an obstacle to important legal objectives. There is no reason to depart from the doctrine of *stare decisis*. *See Patterson*, 109 S. Ct. at 2370-71.

Petitioners argue at length that *Wilder* was decided incorrectly. *Wilder* was decided correctly and we will not reargue it in this Brief. We will point out, however, that even if the Court were prepared to overrule *Wilder*, it

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[12] Pennsylvania's administrative procedure does not afford providers the right to challenge Pennsylvania's payment methodology. *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 30 (1989), *cert. granted and aff'd on different issue*, 111 S. Ct. 1138 (1991).

would not necessarily reverse the decision of the Court of Appeals as to Temple for at least two reasons:

1. The plaintiffs in *Wilder* alleged only that Virginia's rates were not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Temple makes the additional claim that Pennsylvania's rates violate the requirement that the rates adequately "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs" as set forth in 42 U.S.C. § 1396a(a)(13)(A) and expanded by Congress in 42 U.S.C. § 1396r-4. If this Court were to overrule *Wilder*, holding that providers may enforce the requirement that rates be "reasonable and adequate" to meet the necessary costs of efficient providers, it would still have to decide whether a hospital can enforce the "disproportionate share" requirement. Congress has repeatedly focused on the financial needs of "disproportionate share" hospitals, even to the point of enacting an additional section for their benefit. Moreover, the Medicaid Act directly requires rates to take the situation of "disproportionate share" hospitals into account, not merely that the State make findings and assurances. Even if the Court were to overrule *Wilder*, it might well permit a "disproportionate share" hospital to bring an action under 42 U.S.C. § 1983.[13]

2. The plaintiffs in *Wilder* alleged only that Virginia's rates violated the substantive standards of the

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[13] For the reasons stated below, we do not believe that the "disproportionate share" hospital requirement is worthy of this Court's attention.

Medicaid Act. Temple makes the additional claim that Petitioners violated the procedural requirements of the Medicaid Act by making no analysis of hospital costs. Indeed, the Court of Appeals held that Pennsylvania's findings and assurances to the Secretary were "without foundation." (Pet. App. 27a). Even if this Court were to reverse *Wilder* by holding that a provider has no right under 42 U.S.C. § 1983 to require compliance with the substantive requirements of the Medicaid Act, it would then have to decide whether a provider has the right to compel a State to establish rates based on bona fide findings and assurances.

III. THE HOLDINGS OF THE COURTS BELOW ON THE DISPROPORTIONATE SHARE HOSPITAL REQUIREMENT ARE BASED ON FACTS PECULIAR TO PENNSYLVANIA AND TO RESPONDENT TEMPLE.

The "disproportionate share" requirement in the Medicaid Act applies to a relatively small number of hospitals, is rarely invoked in hospital litigation against Medicaid payment rates, has been only rarely interpreted by the courts, and is still being refined by Congressional and regulatory action. The findings of the courts below were based on facts peculiar to Pennsylvania and to Temple. The holding of the Court of Appeals on the "disproportionate share" hospital requirement does not warrant attention by this Court.

As demonstrated above, Congress has repeatedly expressed its concern for the manner in which the States have elected to deal with the situation of high-volume

Medicaid hospitals. Repeated Congressional actions have established both that Congress recognized the special role that inner city hospitals with high Medicaid volumes play in delivering health care to the poor and that Congress intended States to assure the survival of these hospitals by making substantial additional payments to them.

The "disproportionate share" requirements have, however, not been the subject of extensive litigation in the federal courts. Petitioners can show no conflict among the Circuits. The decision of the Third Circuit in Temple's action is the only decision by a Court of Appeals on the substance of the "disproportionate share" hospital requirement.[14] That requirement has been the subject of little litigation because States are required to make these payments to only a small percentage of hospitals.[15] Thus, although Congress expressed particular concern for the treatment of "disproportionate share" hospitals, that concern has not been the subject of any substantial amount of litigation and should not warrant review by this Court.

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[14] The only other decision by a Court of Appeals is *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989), *cert. granted and aff'd on different issue*, 111 S. Ct. 1138 (1991), in which the Third Circuit held that Pennsylvania could not deny "disproportionate share" status to an out-of-state hospital that qualified under the standards applied to in-state hospitals. *West Virginia* did not address the level of payments required for "disproportionate share" hospitals.

[15] In contrast, the Medicaid Act requires States to make payments that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to all participating hospitals, as well as all nursing and intermediate care facilities.

The Petition attacks the opinion of the District Court for imposing on Pennsylvania a requirement applicable to all hospitals that is not included in the Medicaid Act and not supported by any legislative history of that Act.[16] The Petition ignores the fact that the District Court has so far applied its "disproportionate share" holding to only one hospital. The Petition also ignores the facts, unique to Pennsylvania and to Respondent Temple, which form the basis of the District Court's holding:

1. Petitioners established the amount of the payments to "disproportionate share" hospitals without any consideration or analysis of the needs of, or additional costs incurred by, these hospitals. (Pet. App. 80a.) Thus, Petitioners made no bona fide attempt to comply with the Medicaid Act. Their assurances that the rates complied with the "disproportionate share" hospital requirement were "without foundation." (Pet. App. 27a).

2. Pennsylvania's additional payment to those hospitals with the highest Medicaid utilization was only 2.5%. Petitioners' own expert at trial calculated the additional costs of those hospitals as at least 16% above comparable hospitals. (Pet. App. 79a, 80a). The Medicaid add-on would have provided an additional payment of about

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[16] The Petition also argues that the District Court should have given great deference to HCFA's approval of Pennsylvania's "disproportionate share" payment plan. Neither the District Court nor the Court of Appeals could have done so because that approval, if it occurred, was never included in the record of this proceeding. This Court does not permit arguments based on facts outside the record. *Witters v. Wash. Dept. of Servs. for the Blind*, 474 U.S. 481, 486 n.3 (1986); *New Haven Inclusion Cases*, 399 U.S. 392, 450 n.66 (1970).

21% to one of those hospitals, Respondent Temple. (Pet. App. 82a). Thus, there was an enormous gap between what Pennsylvania provided and what objective analysis or the Medicare formula would have provided. The gap was so large it could not be upheld under *any* construction of the Medicaid Act.

Based on these facts and mindful that States are given "a considerable amount of flexibility" in this area, the District Court nonetheless concluded that "Pennsylvania's adjustment for [Temple's] disproportionate-share status misses the mark by so wide a margin as to be inconsistent with the intent of Congress." (Pet. App. 82a). The District Court has not yet extended this holding to other hospitals in Pennsylvania.[17]

In summary, the holdings of the Courts below on the "disproportionate share" hospital requirement relate only to the particular facts of a single State and of the hospital with the highest Medicaid volume within that State. The requirement is still in the process of legislative clarification and regulatory interpretation and has only rarely been the subject of litigation. The issue presented by the Petition does not warrant review by this Court.

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[17] Other Respondent hospitals applied to the District Court for relief on the "disproportionate share" hospital requirement in early 1990. Those applications remain pending.

CONCLUSION

The actions before the Court are the subject of a Stipulation of Settlement which places them in civil suspense in the District Court and makes them subject to possible dismissal on July 1, 1993. As a result, any action by this Court may have no effect on the underlying litigation. In addition, the Petition presents no special circumstances why this Court should reconsider its decision in *Wilder v. Virginia Hospital Association*. For these and the other reasons stated in this Brief, this Court should deny the Petition for Writ of Certiorari.

Dated: November 29, 1991

MATTHEW M. STRICKLER
LAURIE MARTIN

BALLARD SPAHR ANDREWS
& INGERSOLL
1735 Market Street
51st Floor
Philadelphia, PA 19103-7599
(215) 665-8500

Attorneys for Respondent
Temple University – Of the Commonwealth System of Higher Education

Of Counsel:

GEORGE E. MOORE, ESQUIRE
University Counsel
Temple University
435 Carnell Hall
Broad and Montgomery Avenue
Philadelphia, PA 19122

(5)

No. 91-732

In The

Supreme Court of the United States

October Term, 1991

KAREN SNIDER, Acting Secretary of the Department of Public Welfare, Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY – OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

SUPPLEMENTAL BRIEF IN OPPOSITION OF RESPONDENT TEMPLE UNIVERSITY – OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION

Of Counsel:

GEORGE E. MOORE, Esquire
University Counsel
Temple University
435 Carnell Hall
Broad and Montgomery Avenue
Philadelphia, PA 19122

*Counsel of Record

MATTHEW M. STRICKLER*
LAURIE MARTIN
BALLARD SPAHR ANDREWS & INGERSOLL
1735 Market Street
51st Floor
Philadelphia, PA 19103-7599
(215) 665-8500

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

Respondent Temple University – Of the Commonwealth System of Higher Education[1] files this Supplemental Brief to bring to the attention of the Court the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (the "Amendments"), passed by Congress on the afternoon of November 26, 1991.[2] Counsel understands that the Amendments reflect a compromise among Congressional leaders, the Health Care Financing Administration, and the National Governors' Association and that the Amendments are expected to be signed by the President. Counsel has been unable to determine, however, when the President is expected to sign them. Enactment of the Amendments would make the issues presented in the Petition unworthy of consideration by this Court for the following reasons:

1. The actions that are the subject of this Petition have been conditionally settled and the enactment of the Amendments would make the final dismissal of the actions pursuant to that settlement more likely. Specifically, the Amendments, in section 2(c)(3), would nullify the interim regulations of the Secretary of Health and Human Services promulgated September 12, 1991 (and cited in footnote 1 on page 15 of the Petition)[3] and, in Section 2(a), would permit the parties to engage in a

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[1] Respondents in the Hospital Association of Pennsylvania and Albert Einstein Medical Center actions join in this Supplemental Brief.

[2] The text of the Amendments can be found at page H 11865 of the Congressional Record for November 26, 1991.

[3] The September 12, 1991 regulations were superseded by another set of interim final regulations published October 31, 1991 at 56 Federal Register 56132.

pooling transaction during Pennsylvania's fiscal year ending June 30, 1993. Such a pooling transaction would enable the Petitioners to pay the higher rates required by the Stipulation of Settlement during that fiscal year end, if there is no event which would permit a party to terminate the Stipulation, would require these actions to be dismissed on July 1, 1993, regardless of any action by this Court. After enactment of the Amendments, no obstacle should prevent the dismissal of these actions.

2. The Petition asks this Court to interpret language of the Medicaid Act which has limited effect because it is subject to continuing legislative refinement. The Amendments would continue this process. The Amendments, in Section 3, would further amend 42 U.S.C. § 1396r-4, effective January 1, 1992, to limit total add-on payments by all States to "disproportionate share" hospitals to twelve percent of the total payments by all States, but with numerous exceptions. Section 3 would also nullify the interim regulations on "disproportionate share" hospitals promulgated by the Secretary on October 31, 1991 (and cited at page 8 of Temple's Brief in Opposition). Finally, Section 3 would require the Prospective Payment Assessment Commission to conduct a study and to report to Congress before January 1, 1994, concerning the feasibility and desirability of establishing maximum and minimum payment adjustments for "disproportionate share" hospitals and the criteria appropriate for designating "disproportionate share" hospitals. The Amendments demonstrate that Congress is continuing to define those hospitals that must be treated as "disproportionate share" hospitals and the payments that must be made to those hospitals. This court should not use its limited time to

review decisions by lower courts interpreting statutory language that is subject to continuing Congressional refinement.

3. The Amendments demonstrate that, notwithstanding the continuing Congressional interest in refining the provisions of the Medicaid Act, there is no Congressional interest in nullifying or altering this Court's ruling in *Wilder v. Virginia Hospital Association*, 110 S.Ct. 2510 (1990). The Amendments would be a second instance in which Congress has amended the Medicaid Act without taking the opportunity to nullify or alter that decision.

For these reasons and the reasons stated in its Brief in Opposition, Respondent Temple University – Of the Commonwealth System of Higher Education requests the Court to deny the Petition.

Dated: December 6, 1991

MATTHEW M. STRICKLER
LAURIE MARTIN

BALLARD SPAHR ANDREWS
& INGERSOLL
1735 Market Street
51st Floor
Philadelphia, PA 19103-7599
(215) 665-8500

Attorneys for Respondent Temple University – Of the Commonwealth System of Higher Education

Of Counsel:

GEORGE E. MOORE, Esquire
University Counsel
Temple University
435 Carnell Hall
Broad and Montgomery Avenue
Philadelphia, PA 19122